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ORIGINAL LECTURES.

CLINICAL LECTURE ON URETHRAL FEVER.

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Delivered at the Philadelphia Hospital, February 14, 1872.

GENTLEMEN,—I desire this morning to say a few words to you concerning an affection which has not, it seems to me, received from the writers of surgical text-books the attention it deserves. I refer to what is ordinarily known as urethral fever,—a peculiar febrile or irritative condition not unfrequently consequent upon surgical interference with the urethra.

You have in this clinic seen many patients brought before you laboring under the most aggravated forms of genito-urinary trouble; and time and time again you have witnessed, at the hands of my colleagues and myself, the various operations for organic stricture, and for urethral and perineal fistula. In an institution such as ours, the cases of this kind which reach us are usually very grave,—often, indeed, at first sight, desperate. They are in fact those which, so to speak, have run the gauntlet of surgical intervention, and oftentimes find their way here when abandoned elsewhere. And yet I think that I may fairly claim for the surgical staff of this hospital a high degree of success in the treatment of these aggravated cases,—a success which is due, I believe, in the main to the very decided operative interference we are in the habit of adopting.

Rupture of stricture, its over-dilatation, and internal division, or these methods combined, as well as the varieties of external perineal section, are operations with which you are familiar from the testimony of your own eyes. How successful we have been, particularly in the three first-mentioned operations (and I refer to these especially, only because they form so large a majority of our operated cases), you can judge as well as I. You have seen the patients submitted to the different procedures, and most frequently after the expiration of two or three weeks you have seen them walk into this arena relieved of their strictures and ready to be discharged from the wards.

I do not this morning intend to dwell upon the indications of these operations, nor shall I seek to weigh their individual merits in the scale. I take it for granted—indeed, I well know—that all in their proper places are trustworthy procedures. But I do wish now to impress upon your minds, as forcibly as words of mine can, the important clinical fact that each of these operations, no matter how delicately performed, may at times give rise to severe shock and to a high degree of constitutional irritation. I have known death to follow the simple introduction of a catheter,—and that, too, by an experienced hand. Fortunately, such a result is rare, but still it may happen to any one, no matter what his skill may be. I would therefore caution you, in entering upon urethral surgery, always to bear in mind that to be forewarned is to be forearmed; and I beg of you never to forget the exceeding sensitiveness of the organs upon which you are operating, and never to forego any precaution which may tend to lessen the danger to your patient. Remember that it is impossible to deal too gently with him; remember, too, how easy it is to employ a force which may prove disastrous—even fatal. By all means, then, cultivate gentleness of manipulation, and do not for a moment suppose that your surgery is bold, simply because it is rough.

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I have brought before you this morning three patients lately suffering from aggravated urethral stricture, and who have been treated respectively by dilatation, internal incision, and rupture according to Holt's method. Urethral fever has been present in all three. I will read to you the prominent points of their clinical histories, omitting minor details:

STRICTURES—INTERNAL URETHROTOMY.

J. I., æt. 37; admitted October 26, 1871; fireman and engineer on Reading Railroad. Had gonorrhœa thirteen years ago; cured in five or six weeks. Fifteen months since, noticed that his stream of urine was small and forked. In July, 1871, micturition very frequent and urine scanty, passing at times in drops; towards the end of this month, after over-exertion at a fire, retention occurred, which was relieved by the catheter. Since then he has had no trouble until a few days prior to his admission, at which time almost complete retention took place. On the 27th of October I first saw the patient. I found the bladder high above the pubis, evidently greatly distended, and urine dribbling from the meatus. Instrumental examination demonstrated a tolerably tight stricture about one inch from the meatus, and another, long, tight, and resisting, two and a half inches from the opening. By careful management, however, I succeeded in introducing a silver catheter, No. 11 French (5, of the English scale), and drew off from his bladder no less than fifty-seven ounces of urine. The next day I divided the anterior stricture internally by Charrière's urethrotome. After that I endeavored to overcome the posterior stricture by gradual dilatation, but the irritability of the urethra and the general wretched condition of the patient obliged me to discontinue these efforts for three or four weeks. During this time the stream of urine became gradually less and less. On the 12th of December I again divided the anterior stricture, which had recontracted. On the 17th of January I brought the patient before you, and, having etherized him, divided the posterior stricture by internal incision at three points of its circumference, and then with Thompson's modification of Holt's dilator slowly stretched the parts. The stricture was situated about two and a half inches from the meatus, and was about one inch in length. No. 14 English scale was then readily carried into the bladder. After the operation one-fourth of a grain of morphia and five grains of quinine were directed, to be repeated at intervals of three hours in lessened doses. About six hours after the operation the patient had a severe chill of twenty minutes' duration, accompanied by nausea; pulse 130, and feeble. This was followed by vomiting and profuse sweats, which lasted twenty-four hours, accompanied by great prostration, heavily-furred tongue, malaise, and demoralization. Another chill followed, and again the profuse weakening sweats. Urine high-colored and scanty. By the fifth day this condition of affairs passed off, and the patient became convalescent.

Treatment.—Quinia and morphia; sponging of the surface with tepid alum-solutions; acidulated lemonade, with sweet spirits of nitre, milk-punch, milk, and beef-essence. Locally, hop-poultices to the belly and perineum, and absolute non-intervention with instruments. The patient is now well, passes his water readily and in full stream, and a No. 12 catheter can be passed into the bladder. A marked symptom in this case was the great irritability of the stomach and the rejection of all food other than that mentioned.

STRICTURE—PASSAGE OF METALLIC INSTRUMENT.

F. M., æt. 57. English; blacksmith, and of intemperate habits. Had gonorrhœa when 20, 30, and 45 years of age. The last gonorrhœa followed by a five-years' gleet and by considerable urethral constriction. Was kicked in the perineum when a boy. His stream has always been small. The patient states that fourteen years ago, at Manchester, England, a No. 1 flexible catheter was introduced into his bladder after much difficulty; subsequently Nos. 2, 3, and 4. By these he was much benefited. In 1862 came to the United States. In 1868, at Pittsburgh, stricture very bad; No. 3 metallic catheter then introduced, producing great urethral disturbance and followed by retention, which was relieved by a warm bath. November 20, 1871, admitted to Philadelphia Hospital. I found a stric-

ture near the meatus admitting No. 10 French. Four inches from the meatus I encountered a stricture I could not then pass. Stream of urine very small and forked. December 7 I passed the back stricture with fine whalebone bougie; this was followed by pain and straining on micturition, increasing for several days to such an extent as to lead to defecation on each attempt at urination. *Treatment.*—Rest, anodynes, local warmth, etc., under which he gradually improved. February 3, 1872, I succeeded with much trouble, but without force, in passing a No. 10 (French) silver catheter into the bladder. Six hours afterwards he had a very violent chill, lasting one hour; pulse 120, and thready; nausea and prostration. The chill was followed by fever and profuse sweats lasting the entire night, accompanied by vomiting and some cerebral disturbance. On the succeeding day, pulse 108; had a slight chill, followed by sweats which continued with but slight interruptions for four days, the pulse gradually lessening in frequency and increasing in force. The tongue was at first covered with a white fur, which gradually became very dark and thick. The nausea, constantly-recurring vomiting, and loathing of food, were marked. Convalescent on February 8.

Treatment.—Morphia, quinia, acids, chloroform internally, to control vomiting: milk, punch, beef-essence, and local applications to belly and perineum. The urine after operation, although scanty and productive of pain, passed in good stream. He now passes a better stream of urine, and with less trouble, than he has done for twenty years. He considers himself well; and I regard him certainly as improved.

STRICTURE—RUPTURE BY HOLT'S METHOD.

A. M., *et.* 48. Irish; laborer; a man of resolute nerve. Had gonorrhœa twelve years ago, followed by gleet, lasting until within two years. Since the disappearance of gleet the stream of urine has diminished in size,—at times, indeed, passing only in drops and after great straining. Dribbling sometimes took place, both by day and night. Admitted to hospital December 30, 1871. On January 3, 6, 13, and 25, without and with the use of ether, I attempted to pass a stricture just in front of the membranous urethra, but uniformly failed. On the last occasion some slight irritation, which was easily subdued, followed the manipulation. February 3, passed No. 2 (English) silver catheter into the bladder. February 6, etherized the patient, and, before the class, burst with Thompson's dilator a stricture one inch long and involving the membranous urethra. Passed solid bougie, No. 10 English, into bladder. Ordered quinia, gr. v, and morphia, gr. $\frac{1}{4}$; to be repeated. Twelve hours after operation patient had a chill, which lasted twenty minutes, with quick pulse, followed by sweats, slight vomiting, dislike to food, thirst, etc. Tongue moderately furred.

Treatment.—Morphia, quinia, milk, acids, punch, beef-essence, and local fomentations. In two days he was convalescent, and is now well, with easy micturition, better than he has had for many years. You see I pass No. 10 catheter into the bladder without difficulty.

Let me add to these histories the clinical accounts of two patients taken from my private note-book:

OBSTRUCTION IN PROSTATIC URETHRA.

In 1871 I was consulted by a lawyer, aged 55, who had suffered for some years from prolonged and painful urination accompanied by much straining, his stream of urine being small. I examined him at my office by the introduction of a No. 10 English Thompson's sound. As its point approached the bladder I experienced a peculiar and unusual resistance, disappearing suddenly before the gentle pressure of the instrument as the latter passed into the bladder. On withdrawal of the sound some venous blood followed; this venous oozing continued for twenty-four hours. In a few minutes after the operation the patient passed his urine in a stream more full than he had possessed for years, and which has so continued until now. On the evening of this examination he had a very severe chill, marked by nausea, quick feeble pulse, and followed by long-continued prostrating sweats accompanied by great gastric irritability. These symptoms gradually passed away, and in three or four days he became convalescent; but it was not until the expiration of two weeks that he was able

to return to his business. I should state that the urine in this case was albuminous, and undoubtedly renal trouble coexisted.

OLD STRICTURE—CATHETERIZATION.

A gentleman aged about 44, prominent in his profession, consulted me some two or three years since. He had long experienced difficulty in urination, and on examination I detected two strictures, the result of a gonorrhœa eighteen years before. One of these strictures was situated near the meatus; this I divided; and the other, at the membranous urethra, I treated by gradual dilatation, advising him to pass a No. 10 solid bougie every few days. This he did for many months, thus rendering his condition quite comfortable. Not very long since he passed the sound somewhat hastily about 9 o'clock A.M. At 2 P.M. he had a slight chill, with headache and nausea. At 9 P.M. he experienced a most violent chill, followed by profuse sweats, constant vomiting, great restlessness, insomnia, and general demoralization. In this condition he remained for two days, retaining almost nothing on his stomach, sleepless, and nervous. At the expiration of two days from the chill I was called in. I found him tremulous, bathed in sweat, and very weak; indeed, his physical condition closely resembled that of a patient suffering from delirium tremens. The gastric disturbance in this case was decided and prolonged,—the mere sight of food producing at once nausea, and often vomiting. I at once directed the administration of quinia and morphia, milk, punch, and beef-essence, and in a few days he became convalescent.

I have thus, gentlemen, briefly sketched the outlines of five cases, in which, as you will observe, the same phenomena of urethral irritation were developed. I might readily refer to many similar instances occurring in my hospital and private practice; but those I have alluded to are sufficient for my purpose this morning. I have selected these because they represent different grades of operative interference with the urethra,—to wit, the simple passage of the sound, dilatation, incision and rupture of stricture, and the overcoming of some morbid growth—possibly a polypus—at or near the neck of the bladder. Let us now examine more carefully the symptoms offering themselves to our notice in these cases.

First, we have *the chill*. As a rule, I have found that the chill following urethral manipulation makes its appearance in six or eight hours after the time of operation, commencing with a cold or chilly sensation in the back, loins, and limbs, but passing rapidly into a true rigor. In this we have the chattering of the teeth and the shivering jerking tremor of the body which are doubtless familiar to all of you as a stage of intermittent. So intense is the chill I am describing that it would seem to be impossible to overcome it, either by general or local warmth, or by the accumulation of extra blankets and bed-covering. It is an obstinate persistent chill, and one which greatly demoralizes your patient. It usually lasts some time,—from twenty to sixty minutes,—and is almost always, I think, accompanied by considerable nausea. Vomiting, too, may occur, but this perhaps most frequently does not arrive until the beginning of the hot and sweating stages. The pulse is quick and feeble, commonly ranging from 110 to 130, and sometimes wanting in regularity. The surface of the body is cold, the face is pinched, and the extremities of the fingers are pale and contracted. The condition, in fact, is apparently one of collapse.

Sometimes, instead of a single violent chill as described, the patient may experience, some two or three hours after operation, a slight creep, which may pass away, to be followed after an interval by the decided well-marked chill of which I have told you.

Such is the chill. To it succeeds a *hot fever*. As far as I have observed, this latter is of short duration, rarely lasting longer than one or two hours, and rapidly passing into the sweating stage. Strictly speaking, I suppose that I ought to call all that period succeeding the chill

the stage of fever, but I prefer to call it the *sweat*, so marked is this symptom, and so long its duration. The patient is literally bathed in perspiration, and so remains for many hours. Indeed, I have seen this condition last almost without break for two or three days; it may perhaps be interrupted for a very little while, perhaps on the second or third day, by a short chill, but still the distressing feature of profuse weakening sweat continues.

The gastric irritability at this time is very great; the nausea is persistent, with constantly-recurring attacks of vomiting difficult to control. The stomach is impatient; it rejects almost everything, and the very sight or smell of food will often cause it to rise in rebellion. The pulse is quick: I have counted it from 130 to 140; but it is not strong. The urine is scanty and high-colored. The state of the tongue in this stage is marked; it is heavily coated at first with a white fur, which gradually becomes almost of a chocolate-brown, and very dry. The thirst is excessive, and the patient craves acid drinks. Insomnia, too, is present; the sick man cannot sleep sometimes for two or three consecutive days and nights, or, if he should doze, he is disturbed by strange dreams. Restless by day and sleepless by night, you can readily imagine, gentlemen, how wretched his condition may become.

Occasionally patients the subjects of traumatic urethral irritation die; it may be from immediate shock, from exhaustion, or from blood-poisoning and metastatic formations. Usually, however, they recover; the pulse falls, the tongue cleans, the vomiting is arrested, the appetite slowly returns, the sweats cease, the nervousness and tremors are allayed, sleep sets in, and convalescence is established.

Such, briefly told, are the characteristics of the urethral shock, fever, or irritation, as I have observed it. It is a capricious fever, appearing at times when least looked for, and after the most delicate interference with the urethra, but absent at other times after most serious operations, when you would almost expect its presence. The liability to its occurrence does not seem to be influenced so much by the character of the operation, or by the pain experienced, as by some peculiar unknown susceptibility on the part of the patient. Perfect anaesthesia will not certainly prevent its advent, nor will the patient's suffering necessarily induce it. I think, however, that I have observed that in deep strictures with coexistent perineal fistulae, rupture is less apt to be followed by irritative symptoms than where these fistulous tracts do not exist.

From the remarks I have already made, and from the clinical histories I have submitted, you will, I think, gentlemen, properly appreciate the gravity of the affection we are discussing. Let me now add a few words as to its *treatment*. And first, are there any measures which may be resorted to to lessen the likelihood of the occurrence of all these disagreeable symptoms? You have witnessed frequently the precautions I take when about to operate upon the urethra. Before placing the patient upon the table for the administration of the anaesthetic, I usually give him, as a good stimulus, some whiskey or brandy. Then during the operation I take especial care that he shall not be chilled: I do not uncover him unnecessarily; I see that his body and lower extremities are well wrapped in blankets; and I protect him in every way from draughts of air. I look upon all this as very important, for I know that I have seen mischief result from the neglect of just such precautions. Then after the operation I generally empty the patient's bladder with a catheter, and I direct that he be wrapped in a blanket and placed in bed, first taking care to remove from his person any portion of his clothing which may be wet. As soon as he recovers from the anaesthesia, and can swallow, I administer (as has been re-

commended by Sir Henry Thompson) a full dose of morphia and quinia,—one-quarter of a grain of the former and five grains of the latter,—and every two or three hours afterwards I give him, until he sleeps, one-eighth of a grain of morphia and two or three grains of quinia, or more if necessary. I seldom leave any instrument in the urethra; I believe that this is not often necessary. A catheter, at the best, is but a foreign body, and its presence frequently will produce irritation and give rise to the very symptoms you would most avoid. Soothing applications to the supra-pubic region and to the perineum I like much. You may employ very light hot cataplasms dashed with laudanum, or the old-fashioned excellent hop-poultice.

You have thus done everything to avert a chill. If it should come, you will have the satisfaction of honestly believing that it was unavoidable. You can only administer hot stimulus, apply hot-water bottles and dry warmth generally, and prepare to carry your patient through the next weakening stage as best you may. How will you treat the sweat? Here you must rely chiefly upon morphia and quinia. If regularly given and persisted in, the controlling effect of this combination will very soon be recognized. The muriated tincture of iron would seem at first sight to be peculiarly adapted to the sweat, but its tendency to increase rather than to allay the gastric irritability renders it objectionable. As a local application I would recommend frequent sponging of the entire surface of the body with strong tepid alum-water. This will be found very grateful to the patient, and really seems to exert some effect upon the excessive diaphoresis. The nausea, and especially the vomiting,—such marked features in this stage of the affection,—can best be controlled by the internal administration of a few drops of chloroform, and by the application of mustard-plasters upon the pit of the stomach.

The selection of the proper *diet* is a matter of great importance. I have already spoken of the loathing of food, and of the tendency of the stomach to reject its contents upon the slightest provocation. I advise you, therefore, in this matter to rely at first chiefly upon iced milk and milk-punch. If carefully administered in small quantities, these will usually be retained; and a little later, as the stomach loses somewhat of its irritability, beef-essence, well made, may be attempted. If you find that this is not rejected, you may then regard your patient as on his way to convalescence. The distressing thirst can be best allayed by the free administration of iced lemonade, or of lemonade to which carbonic acid water, or a small quantity of aromatic sulphuric acid, has been added, varied occasionally perhaps by iced champagne.

Before bringing my remarks to a close, there is one other piece of advice which I would offer you; and that is carefully to abstain from all instrumentation upon the urethra of your patient until the irritative symptoms shall have passed away. By doing otherwise you can effect no good, and there are a thousand chances to one that you will increase the already-existing evils. Remember, gentlemen, the old adage that "a meddling midwifery is bad;" and believe me that it is possible to meddle with a urethra in its tribulation with no better a result than that which falls usually to the lot of meddlers elsewhere.

CHLORAL CONTRA-INDICATED IN SURGICAL INJURIES AND OPERATIONS.—Dr. John Neill, of Philadelphia, briefly reports, in the *American Practitioner* for February, 1872, a case of gunshot-wound in a boy aged ten years, in whom there was reason to believe that great depression had been produced by the use of chloral. Great improvement took place when it was substituted by morphia.

ORIGINAL COMMUNICATIONS.

FIBRO-CYSTIC TUMOR OF THE UTERUS,
SUPPOSED TO BE OVARIAN.

REMOVAL—RECOVERY.

BY HUNTER MCGUIRE, M.D.,

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L. C., æt. 24 years, a cook, married, from Fredericksburg, Va., was admitted to the College Infirmary July 18, 1871, with a large smooth abdominal tumor of five years' growth. She gives the following history: Menstruation began at fourteen years, and, except the interruptions caused by pregnancy or lactation, has continued regularly to the present time. Has never had dysmenorrhœa or menorrhagia. Has had two children, both now living; no miscarriage. After the birth of her first child, five and a half years ago, she discovered a tumor about the size of a hen's egg in her left iliac region. In eighteen months from the time she first noticed it it grew to about the size of a goose-egg, was painless, hard, smooth, and apparently very loose in the abdomen. She could pull it up and make it nearly touch the costal cartilages, or let it gravitate into the pelvic cavity beyond the reach of her fingers. She could feel it move about when she changed her position in bed. Becoming pregnant again, the tumor disappeared until after the birth of her second child, when it was found to have grown to about the size of a cocoanut. The enlargement continued slowly until about six months ago, when it began to increase rapidly, and soon rendered her unfit to continue her work as a cook. Until disabled by this tumor she had been a strong healthy woman, rarely ever sick, and with no hereditary predisposition to disease.

Upon examination the thoracic organs were found healthy, appetite good, bowels regular, urine normal. She was somewhat anæmic, and her face sad and depressed. The circumference of her abdomen at the umbilicus was forty-one inches; from ensiform cartilage to pubis sixteen inches. The tumor is smooth, except in the left iliac region, where its surface presents some slight irregularities. It is quite mobile, and when pressed against the anterior abdominal walls a slight crackling noise or crepitation is felt and heard at a short distance. Fluctuation above the umbilicus is very distinct. In the right iliac region it is not so plain, but certainly present. In the left iliac it is very obscure, if felt at all. The uterus is in its natural position; sound enters three (3) inches. The organ is mobile, but when moved imparts no motion to the tumor. Examination with the finger, by the vagina and rectum, shows the pelvic cavity filled with a dense hard mass, slightly movable, and when moved giving some motion to the abdominal tumor.

Diagnosis.—Ovarian tumor, composite in character. The sixth day, at my request, the case was examined by Professors Wellford and Cunningham and Drs. Thomas and Fairfax, of this city; and, although there was some difference of opinion as to its exact nature, they agreed that the tumor was ovarian, and advised an operation. The woman was exceedingly anxious to have the operation performed, although fully aware of its danger. She knew that a patient from whom I had removed a large ovarian tumor had died in the hospital two days before she arrived here; but the fact did not alter her determination to have the operation performed, nor lessen her sanguine expectation of recovery. Throughout her long and painful sickness she never for one moment despaired of getting well.

A full dose of castor oil was given the day before the operation, and the patient's bowels were still further relieved by an enema the next morning. July 24, assisted by Drs. Thomas, Cunningham, Wellford, Taliaferro, White, and Upsher, and in the presence of a large number of medical gentlemen of this city, chloroform was given and the operation performed. The usual median incision, three and a half inches in length, was first made. The sac exposed was evidently very thick, and darker than usual. No adhesions were found with the finger or with a long steel sound, except in the left iliac region. Spencer Wells' trocar was passed into the cyst, and eighteen (18) pints of dark-brown fluid discharged. As the contents of the tumor escaped, compression of the abdominal walls was made by the hands of the assistants, and the thick cyst-wall collapsed and

was thrown into several large folds. Finding it would be impossible to remove the mass through the abdominal incision, the opening was enlarged to the umbilicus, and afterwards the incision carried one inch above that point. The adhesion in the left iliac region was now examined, and found to be a broad fold of peritoneum containing a portion of the small intestine. It was very vascular, and was spread out like a wing over the left side of the cyst. A strong silk carbolized ligature was thrown around this adhesion and tied. In course of the subsequent manipulations to find the exact attachment of the cyst, this ligature slipped, and ten or twelve ounces of blood were rapidly lost. Two silver-wire and one thread ligature were now employed, and the vessels secured. The ends of the thread ligature were cut off, and the wire ligatures were twisted, the ends cut off and turned down. The cyst was then lifted from the abdominal cavity, and its pedicle, which was attached to the left side of the fundus of the uterus, crowded into Atlee's new clamp. The cyst was then cut away, the abdominal and pelvic cavities cleansed, and the wound closed with silver-wire sutures, the deep stitches including the peritoneum.

The operation lasted two hours.

The weight of the cyst was eight pounds; adding the nine (9) quarts of fluid, the weight of the whole mass was about thirty pounds. The tumor was evidently a fibrous growth which had undergone cystic degeneration. The cyst-wall varied in thickness in different places; that portion situated above the umbilicus was about one-fourth of an inch in thickness, in the right iliac region from three-fourths of an inch to one inch in thickness, and in the left iliac region the wall was nearly two inches thick. About one and a half pounds of decomposed fibrine was found in the cyst after its removal.

Reaction came on gradually after the patient was put to bed, and was complete in two hours. Ice and barley-water were given at short intervals. At 7 P.M., pulse 112; urine, by catheter, 10 ounces. No opium or whiskey given.

July 25.—Slept a little last night. Pulse 124. Slight nausea. Twenty-five ounces of urine passed during last twenty-four hours. Ice and barley-water allowed; no opium or whiskey.

July 26.—Nausea increased. Slept very little. Pulse 150. Abdomen tympanitic and tender. One-half grain of morphia given hypodermically, and one-half ounce of whiskey every two hours. Abdomen to be covered with flannel wrung out of hot water and sprinkled with spirits of turpentine. Wound protected with lint and oil-silk. Urine 17 oz.

July 27.—Tympanites less. Pulse 150. Morphia, one-fourth grain every six hours; whiskey, one-half ounce every two hours; beef-tea and barley-water. Urine 19 oz.

July 28.—Abdomen still tympanitic and tender. Pulse 155 and very weak. Tongue moist. Hot fomentations and morphia continued as before; best French brandy substituted for whiskey. Urine 28 oz.

July 29.—No apparent change. The wound was dressed, and some of her bed- and body-clothes were changed. Pulse 150. Urine 21 oz. Same treatment.

July 30.—Slept right well; says she is better. Pulse 160. Urine 28 oz. Chicken-essence and soft-boiled egg in addition to the beef-tea.

July 31.—Offensive discharge of blood and pus from wound. Carbolic acid (one part to forty parts of water) used on dressing. Pulse 140. Urine 31 oz. Same treatment.

August 1.—Wound looks well; discharge less. Tongue dry. Pulse 145. Urine 38 oz. Asked for chicken-soup, which was given. Morphia and brandy as before.

August 2, A.M.—Rested well last night. Pulse 130. Ate for breakfast two eggs, rice, and coffee. In addition to morphia and brandy, one-half grain sulphate of quinia to be given every three hours.

8 P.M.—Head affected by quinia. Urine 100 oz. in the last twenty-four hours. Quinia omitted; brandy and morphia as before.

August 3.—Clamp came away. Discharge from wound dark and offensive; upper two-thirds of wound closed. Urine cloudy; 102 oz. during twenty-four hours.

August 4.—Gave enema, which moved the bowels very well. Pulse 116. Urine 67 oz. Woman more cheerful. Fifteen drops tincture chloride of iron every six hours, in addition to the other remedies.

August 5.—Had voluntary discharge from bowels and bladder. Pulse 120. Urine 76 oz.

August 6.—Slept some last night after the usual dose of morphia, but the rapid accumulation of urine, requiring the use of the catheter, disturbed her. Catheter used every two hours. Urine in last twenty-four hours 104 oz.

August 7.—Pulse 120. Urine 100 oz. She is still unable to empty the bladder herself, and the frequent introduction of the catheter is painful. Wound healing and discharging less. No tympanites or soreness of abdomen. Chloral substituted for morphia; other treatment the same.

August 8.—Pulse 112. Urine 86 oz. Had mutton-chops and soup, with bread, for dinner.

August 9.—Restless badly, and is very feeble. Some blood and pus discharged from wound. Pulse 116. Urine 100 oz. Brandy stopped, and extract of malt substituted. Bowels moved.

August 10.—Slept well and feels better. Pulse 116. Urine 49 oz.

August 11.—Pulse 104. Urine 76 oz.

August 12.—Slept well. Pulse 108. Urine 81 oz. Bowels moved. Extract of malt in place of the brandy and chloral in place of the morphia still continued.

August 13.—Pulse 92. Urine 68 oz. Stronger and more cheerful.

August 14.—Wound contracting. Bowels moved. Pulse 92. Urine 74 oz. Appetite good.

August 15.—Pulse 90. Urine 76 oz. Woman better and stronger.

August 16.—Pulse 90. Urine 64 oz. In addition to other remedies, gallic acid was given to-day.

August 17.—Pulse 108. Urine 100 oz. As gallic acid did not diminish the quantity of urine, it was discontinued. The malt and chloral were continued, and fifteen drops of tincture of chloride of iron given three times a day, after meals, and fifteen drops of aromatic sulphuric acid, with two drachms of tincture of cinchona, before meals.

August 18.—Restless well. Appetite good, and strength increasing. Pulse 98. Urine 90 oz.

August 19.—Pulse 96. Urine 64 oz.

August 20.—Pulse 88. Urine 48 oz.

From this date she continued to improve until August 30, when she was able to leave her bed and walk about the room.

September 3.—Discharged from the hospital. She is now able to walk up and down two flights of stairs, and to wait upon herself. The wound has nearly closed; discharge from it very slight. The urine diminished in quantity until August 30, when the amount was normal. It was repeatedly examined during her sickness, and on two occasions (August 6 and 9) was found to contain pus in large quantities. August 6 the quantity of pus was so large and suddenly produced that I was under the impression that an abscess had formed and opened into the bladder. With the exceptions of the presence of pus and the unusual quantity of water, there was nothing unnatural about the urine. One of my friends—a very excellent chemist—discovered oil; but, as this substance was used upon the catheter when introduced into the bladder, its presence was easily accounted for.

October 30.—Lucy called at my office to see me to-day. The silk ligature had made its appearance at the wound, and came away after a little traction. Except the small opening occupied by the ligature, the wound has closed. The cicatrix is very much depressed, and looks as if it was under the influence of some traction from within the pelvis. The bottom of the scar is an inch below the level of the healthy skin around it. She looks well and strong.

December 30.—A letter from Mr. Carter, of Fredericksburg, received to-day: "Lucy is now employed by me; directed the cooking for my family and a little light washing for my daughter. She is very well."

Another letter from Fredericksburg, received February 17, 1872, says that Lucy is still at work cooking and washing, and that she is very well.

I am indebted to Dr. Taliaferro, Superintendent of the hospital, for the great care and attention he gave to this case; and to Dr. H. Thomas, for his valuable assistance. He visited the woman daily, and sometimes, during my absence, directed the treatment.

All systematic writers that I have been able to con-

sult upon the subject of ovarian cysts and fibro-cysts of the uterus agree that a positive diagnosis between these affections is not possible. Thus, Graily Hewitt says, in his work on "Diseases of Women," fibro-cysts of the uterus "are very rare, and it seems almost impossible to say how they are to be distinguished from cases of ovarian tumors during life." Mr. Spencer Wells makes the following statement: "Even after an exploratory incision, I know of nothing but a rather darker—less pearly-blue—aspect of the tumor which would put the surgeon on his guard." Mr. Baker Brown says, "The diagnosis between these very rare tumors and encysted ovarian disease must be more difficult than in the case of solid tumors. Indeed, I know of no distinguishing marks between the two." In a very valuable and interesting paper, from which the above extracts from authors have been taken, republished from the *New York Medical Journal* (November, 1871), upon The Diagnosis of Ovarian Tumors from Fibro-Cystic Tumors of the Uterus, by C. C. Lee, M.D., of New York, nineteen cases of operations for fibro-cysts of the uterus, by different surgeons, are reported, in eighteen of which they were mistaken for ovarian cysts. The fact that recent investigations of this subject make the diagnosis of fibro-cysts of the uterus really more difficult than it formerly seemed to be is disheartening, but nevertheless true. Thus, Dr. Lee's report shows that three symptoms, upon the presence or absence of which we mainly depended in making a diagnosis, are really of little or no value for this purpose. The first, and most important, because it has so frequently contributed to mistakes in diagnosis, is menorrhagia, which "is seldom found to exist in fibro-cystic disease." The cases reported show that flooding rarely precedes or accompanies this affection.

Independent mobility of the womb, to which much value has been attached, "really indicates nothing but the absence of pelvic adhesions;" "and lastly, the uterine hypertrophy, or increased length of the cavity, upon which much reliance has been placed, is shown to be of very doubtful value by Dr. Routh, who has found the greatest amount of elongation in certain ovarian cases." Dr. Lee is entitled to the thanks of the profession for presenting these facts so ably and conclusively. A knowledge of them will certainly serve to prevent some of the errors of diagnosis heretofore committed. I propose, however, to examine the points of difference between ovarian cysts and uterine fibro-cysts which Dr. Lee gives as the sum of all our knowledge upon this subject, so far as differential diagnosis is concerned:

IN OVARIAN CYSTS,

1. Disease may occur at any period, even before puberty.

2. Development rapid: usually under two years.

3. Aspect of face unaltered if general health be fair.

4. Fluctuation equable over whole surface of tumor.

5. Vaginal examination shows little displacement of uterus; mass smooth and distinct from uterus.

6. Mobility of uterus independent of tumor from beginning. Pelvic adhesions rare.

IN FIBRO-CYSTS OF THE UTERUS,

1. Scarcely ever occurs under thirty,—generally from forty to fifty.

2. Development slow: generally over two years.

3. "Facies uterina" generally marked. Expression anxious and dejected.

4. Fluctuation confined to certain regions,—generally to upper portion, while lower is hard and dull.

5. Vaginal examination shows uterus high up or displaced; mass either not detected or continuous with uterus.

6. Independent mobility of womb confined to last stage of disease. Pelvic adhesions common.

IN OVARIAN CYSTS,

7. Tapping causes complete collapse of unilocular cysts; in polycystic tumors it reveals the endocysts.

8. Fluid clear, straw-colored, serous; or viscid, clear, mucoid, albuminous.

9. When exposed by gastrotomy, sac is pearly-blue or white and glistening; rarely vascular.

IN FIBRO-CYSTS OF THE UTERUS,

7. Tapping causes only partial collapse, leaving base of tumor firm and indurated.

8. Fluid brownish, bloody, sero-purulent, muddy; or thin, yellowish, containing shreds of lymph or cholesterol.

9. Exposed sac dark, vascular, thick, and frequently fasciculated with fibrous bands.

In regard to the *first* point, Dr. Lee's table shows two cases of fibro-cysts of the womb occurring in women under thirty years of age. Add the case just reported, and we have three out of twenty cases under thirty. This fact renders this rule almost valueless.

Secondly, as to the slow or rapid *development* of the growth. It is well known that a subperitoneal fibroid may undergo cystic degeneration and increase as rapidly as an ovarian tumor. There is nothing, then, in this fact upon which the surgeon can rely.

Thirdly: aspect of face.—It would be very difficult to distinguish true "*facies uterina*" from the face of one who is anxious and depressed at the prospect of a dangerous surgical operation, or of one whose health has been impaired by long-standing ovarian disease.

Fourthly: fluctuation.—In a multilocular ovarian tumor, partly fluid and partly solid, such as the foregoing case was supposed to be, we would expect to find fluctuation confined to certain regions, and the lower part hard and firm.

Fifthly: vaginal examination.—In the case reported the uterus was little, if at all, displaced; the mass was detected through the vagina, and apparently not continuous with the uterus.

Sixthly: mobility of uterus.—The surgeon generally sees the case in the last stage of the disease, and can rarely get any previous history except so far as the patient herself can furnish it.

Seventhly: tapping.—This is a valuable test, but certainly attended with danger. The peritoneum would not bear the presence of a portion of the contents of a fibro-cyst of the uterus as it would the fluid of an ordinary ovarian cyst, and it would be almost impossible to avoid the escape of some of the fluid into the peritoneum. In a case reported in the *London Journal of Medicine* for July, 1850, by Mr. Hewett, and referred to by Baker Brown in his "*Surgical Diseases of Women*," p. 191, American edition, symptoms of low peritonitis appeared two days after tapping a fibro-cyst of the uterus, and the patient died on the eighth day. Fifteen pints of thick reddish fluid, with blood and flakes of lymph, were drawn off.

Eighthly: character of fluid.—This too is a valuable test, but dependent on the last.

Ninthly: appearance of exposed sac.—Also valuable, but the operation not free from danger.

I believe, then, that, with the exception of the uncertain "*facies uterina*," we have no means of diagnosing a fibro-cyst of the uterus from an ovarian cyst, except by an exploratory incision and an inspection of the sac, or by the more dangerous procedure of tapping and an examination of the contents of the tumor.

A DOUBLE MONSTER.—Dr. Alexander Klein reports, in the *Wiener Medizinische Presse* for December 24, 1871, a case of this kind resembling that reported by Dr. William Goodell in vol. i. p. 332 of this journal, except that instead of three there were four perfectly-developed lower extremities.

The children were born September 6, 1871, in Hungary.

BRONCHIAL DILATATION IN FOWL.

BY W. H. WINSLOW, M.D.

IN vol. i. No. 14 of *The Medical Times*, I called attention to a singular rupture of the bronchus of a wild duck, and the subsequent efforts of nature to occlude the opening. Since then I have examined many specimens in fowl, and have lately found in the tame duck two well-marked cases of excessive dilatation of the trachea at the division into the bronchi. No ruptures had occurred, yet the last two rings of the trachea, in both instances, were joined homogeneously together and enormously hypertrophied and dilated. Upon the left side of each a pouch sufficient to hold $\frac{2}{3}$ in had been formed, oval in shape, and projecting outwards and upwards about two diameters of the main tube. The outermost portion of the pouches was much thinned, and probably would have soon ruptured. The material of their walls was almost pure cartilage, covered by minute lines in variegated patterns. Extending partly over this were the layers of fibrous tissue prolonged from the outer layers of the trachea. Some obstruction had evidently occurred, which had been overcome by this successful attempt to increase the diameter of the tube. The foreign body had lodged in the left bronchus, *au contraire* to such lodgment in human beings,—which is singular only from the fact of its having occurred in these three cases upon the same side; because the bronchi of a duck, and, indeed, of most fowl I have examined, are of the same size, and their attachment to the trachea seems to be at the same angle on either side. There would appear to be a tendency to easy dilatation in these parts among the feathered tribe, and an easy accommodation of the breathing-apparatus to obstructions, probably occasioned by their omnivorous habits. The longitudinal muscular fibres of the trachea are beautifully shown in these animals, and such dissection is pleasant and instructive to the anatomist, as well before roasting as afterwards. Should the Society for the Prevention of Cruelty to Animals prevent us from studying physiology and anatomy *au naturel*, we can still find some comfort in consulting the cook and the market-basket.

ON NATURE'S LOTION AND ITS IMITATION BY ART.

BY FREDERICK P. HENRY, M.D.

IT has long been a matter of common observation in medical and surgical practice, that the curability of a disease bears an inverse ratio to the number of remedies recommended for its treatment. It is unnecessary to give examples in support of this position, for I do not think it is contested by any one. The fact is easily explained: the pathology of the disease is not understood, and the treatment is therefore empirical; every man has his own theory and his own mode of treatment.

In the matter of surgical dressings, empiricism has long been, and, for aught I know to the contrary, is still, the rule. This may at first sight appear to be an exceedingly bold statement; but is it not the fact that every surgeon has his favorite dressing? Multiplicity of dressings in surgery implies empiricism in that department of the healing art, as does multiplicity of drugs in medicine. One surgeon prefers cerates, another water-dressings, a third applies oil or laudanum, or a solution of carbolic acid, while still another believes firmly in the *vis medicatrix* of our mother earth. The results from all of these applications are declared to be good; so perhaps were the constitutions of the patients in whose cases they were used. Nature accomplished the cure, and the dressing got the credit of it.

Anything new, recommended by high authority, is seized upon with avidity, showing how limited was the confidence reposed in the former modes of treatment. Witness the case of carbolic acid, the use of which in surgical dressings is now comparatively limited.

Now, it is in the study of nature that advance in medical science is most surely and rapidly made. What is nature's lotion for wounds, ulcers, or contusions?

The saliva. A child who cuts or bruises his finger puts it in his mouth: indeed, adults naturally do this. In the mouth it is bathed by the warm saliva, and a certain amount of relief from pain is quickly obtained. Some of the lower animals lick their sores constantly until they are healed. It would seem, therefore, *a priori*, that an application to wounds or ulcers resembling as closely as possible the saliva would be beneficial. The soothing and healing influence of the saliva is probably owing to its three principal characteristics,—namely, its warmth, its slight viscosity, and its alkaline reaction. Any one will perceive that a fluid closely resembling the saliva in these respects could be artificially compounded, with little or no difficulty. The warmth could be retained as it is in the ordinary water-dressing,—the body itself preserving the temperature of the lotion as it preserves the temperature of the saliva in the mouth. Viscidity could be imparted by albumen,—which, indeed, exists in the saliva as well as its proper organic substance, ptyaline,—and alkalinity by soda, lime, or potash, or all three together.

I do not consider that any objection to the argument lies in the fact that ulcers frequently occur in the mouth, especially in children. In such cases digestion is invariably impaired, and the constitution of the saliva—one of the digestive fluids—is probably vitiated.

I have had no opportunity of testing practically the value of a lotion such as I have, in general terms, described; but, as it seems to savor less of empiricism than the applications ordinarily made use of, it is to be hoped that a trial of it will not be neglected.

ABSTRACTS.

BY ROBERT STONE, M.D.,
Irvington, N.Y.

A FEW CASES OF PLASTIC OPERATIONS ON THE SKIN.—Drs. Heiberg and Schulz (*Berlin. Klin. Wochenschr.*, No. 10, 1871) transplanted in fifty cases portions of skin upon granulating wounded surfaces, of which the greater portion healed completely. Among these latter were seven flaps of skin taken from other persons. In the majority of the successful cases of transplanting, the piece varied in size between a lentil and a sixpence sterling; where it was more extensive the transportation invariably miscarried. The writers advise the employment of a fenestrated forceps for seizing the flap of skin, as they had repeatedly observed a central mortification of the flap when it had been seized with the ordinary forceps. For fixing the flap, where the wound is below the level of the surrounding skin, they advise loose cotton-wool laid under the adhesive plaster; for when charpie is used a displacement more easily occurs. In two cases where, on the second day, the piece of skin was found swimming in pus, they succeeded, after previously exciting the granulations, in readjusting the flap of skin and obtaining a healed wound. The first change of dressing should be on the third day, the second on the sixth. In the cicatrized flap on the seventh day a constantly-increasing epithelial line is observed, lying somewhat below the level of the surrounding granulations. Sensibility was not restored in the transplanted portion after five weeks.

Dr. Rauke, in the *Bayer. Aertz. Int.-Bl.*, No. 8, 1871, describes a carefully-observed case of transplanting in a girl six years old. She had received a severe and extensive burn on July 3, and came under treatment December 2. The cicatrization became arrested, as the doctor attested by repeated examinations, during nine days. On December 12 two transplantings were made at the following points: on the inner side of the left upper arm there was an ulcer three centimetres broad and three and a half centimetres long, and at the corresponding region of the thorax an ulcer five centimetres broad and four centimetres long. The upper arm and the breast had grown together as far as the angle formed by these two granulating surfaces; the arm could therefore be moved only to 45° from the body. The flap of skin was then attached in the neighborhood of the upper edge of the thoracic ulcer, in order to counteract as far as possible any further growing together between the arm and the side. The flap took hold, and there also appeared an increased activity in the process of cicatrization over the rest of the wounded surface. On December 20 a thick layer of epidermis was thrown off from the transplanted locality, so that this latter appeared deeper than the surrounding skin; but the healing process went on, and on January 7 (that is, after twenty-seven days) the cicatrization was complete and all further growing together of the two surfaces guarded against.

PESSEMA, A NEW SKIN-DISEASE.—Beigel, in *Virchow's Archiv*, vol. xlvii, pp. 367-370, has described a disease of the skin which he calls papilloma area-elevatum. The patient, aged one year, presented, on the face, arms, and legs, elevations about an inch in diameter, upon which crusts formed, and, upon the removal of the latter, a spongy state of the tissues was disclosed.

Dr. Berg (*Deutsch. Klinik*, No. 15, 1871), about a year before this, had observed the following case: A prostitute, forty-seven years old, who had suffered repeatedly from syphilis, presented on November 25, 1868, on the face, an eruption which might be compared to that of variola, with enormous pustules. The elevations were of the size of a large backgammon-counter, were covered by skin, regular, of a smooth surface and yellow color, were hard to the touch, and were surrounded by a red areola. Pressure detached the thin covering of skin, and there issued a few drops of pus from a mass of minute depressions; on removing the pus an injected reticulated tissue was exposed. The right side of the forehead presented two such elevations; the left, a number of smaller ones; on the face were several of equal size with those first mentioned, from twenty to twenty-four millimetres in diameter. The hairy scalp presented a few abortive pustules. Upon the point of the tongue was a single pustule; upon the sternum were two pustules of the size of a pea.

During the following days the elevations on the face enlarged, and on the trunk several new ones appeared. Nine days from the commencement the elevations on the upper part of the face began to dry up considerably, while those on the lower part remained unchanged; the crusts of the former soon fell off,—the scars being in some cases slightly elevated, in others slightly depressed. Then followed similar crusts on the remaining pustules. About four weeks after the first observation, all the crusts on the face had fallen; the resulting scars were smooth, not depressed,—like slight pock-marks, only of greater dimensions. Those on the trunk followed the same course. On February 8, 1869, the patient was dismissed cured.

Six months later the patient died of morbus Brightii. At the post-mortem examination reference was had to the evidences of syphilis only; in the ossa parietalia

and in the os frontis was found inflammation, and, besides this, pachymeningitis.

The author had extirpated, previous to death, a portion of one of the elevations, and examined this, as well as a portion hardened by chromic acid, under the microscope. The piece, washed in distilled water, presented a granulated tissue; small round granulated cells, with one or two slightly-granular nuclei; the cells lay close together in a slight structureless intermediate tissue. Numerous capillary vessels made the similarity to the granulations of wounds complete; on picking apart minute shreds of the chromic acid section the vessels remained behind as a fine close network with elongated meshes. The papillæ were not included in the section, but the author believes that they are hypertrophied in this affection.

In regard to the etiology, the author calls attention to the fact that, a half-year previous to the appearance of the eruption, the patient suffered from a severe headache, which was decidedly increased a week before the eruption, and then disappeared. (The boy-patient of Beigel was attacked, before the appearance of the eruption, with convulsions, which then ceased.) Dr. Berg suggests a vaso-motor neurosis; he does not regard the syphilis as the producing cause. Therapeutically, he says, there was no call for active treatment. Cataplasms of cold water, and subsequently, as the crusts began to form, compresses with oat-water, lead-water, and applications of the lunar caustic, were employed.

Beigel called the disease papilloma area-elevatum; but, since a hypertrophy of the papillæ occurs in the most dissimilar eruptions (and in the one in question it has by no means been confirmed), Dr. Berg rejects this appellation, and prefers, in consideration of the resemblance of the elevations to checker-men (*παισίδες*), the name *pessema*, since our slight knowledge of the pathological anatomy of the diseased state of the skin does not permit of our adopting a name derived from the diseased process itself.

ON THE ACUTE ANÆMIA OF PREGNANCY.—Professor Gusserow (*Arch. f. Gynæcol.*, ii. 2, 1871) saw in his clinic, in the years 1868 to 1870, five cases of the most intense anæmia in pregnancy, all of which ended fatally. The histories of the patients, as well as the post-mortem evidences of these cases, which are given in the most extended detail, are completely similar. In all an intense anæmia was developed at the latter half of gestation, without any apparent cause; in all the birth was premature (about the eighth month); and, although this occurred easily and without hemorrhage, death followed speedily,—in one case even before the expulsion of the placenta,—in spite of all therapeutic measures, even transfusion. The autopsy presented nothing but a high degree of anæmia and hydræmia.

Now, if we assume—what is generally the case—that the normal state of the blood in pregnancy is that of anæmia and hydræmia, we are inclined to regard the above condition as a pathological increase of a physiological condition. Besides this, the absence of every other etiological cause and the parallel increase of the disease with the progress of the gestation render it very probable that this high grade of anæmia is dependent, although in some unexplainable manner, upon pregnancy itself. Arterial transfusion in similar cases might succeed. Dr. G. suggests the induction of premature labor in such cases, with, at the same time, one or two transfusions.

ON PUERPERAL FEVER.—Martin says (*Berl. Klin. Woch.*, 32) that the true fundamental cause of child-bed fever is always a diphtheritis of the external or internal genitals, whose direct products may disappear so rapidly that they are not discoverable in the cadaver. The opaque serous infiltration of the peritubine connective

tissue never occurs primarily, but is always the consequence of diphtheritis. An autochthonous origin is highly improbable. According to recent observations, the disease originated in places where its transmission could be explained by the decomposing purulent remains, or in consequence of a previously-existing gonorrhœa.

TROPHIC DISORDERS CONSEQUENT UPON PERIPHERIC INJURIES.—Dr. Schiefferdecker gives the results of six cases:

1. Gunshot-wound in the left lower arm; the ulna splintered, ulnar artery and nerve injured. After recovery, paralysis of the extensors of the lower arm, the last finger strongly flexed; severe continuous pains in the limb, often accompanied by creeping sensations. Sense of touch impaired. Marked atrophy of the muscles. The skin raised in a fold, thicker and harder, of a browner color, reddened in spots; great desquamation, and hair and nails atrophic; an increased secretion of strong-smelling sweat; the temperature, subjective and objective, cooler.

2. Gunshot-wound of right upper arm, without injury to the bone. Immediately after the injury the fingers contracted; later on, creeping sensations, and disintegration of the epidermis in strips. After a few weeks, a swelling of the size of a bean was perceptible on the median nerve. Skin harder and thicker, and of browner color. Growth of hair increased, nails curved like claws, increase of sweat, temperature cooler.

The remaining four cases presented entirely similar trophic disorders, except that the copious desquamation of the epidermis and its deeper coloration were absent in three cases.

Dr. S. calls attention to the fact that the majority of the ascertained disorders (atrophy of the muscles, thickening of the skin and its deeper pigmentation, desquamation, increased growth of hair, and lowering of the temperature) occurred *above the seat of injury*.

As cause of the above, like Samuel in the case of the secretion of the nails and hair, Dr. S. attributes it to a disorder of the trophic nerves. As for the other phenomena, he argues, with Leyden, as follows: that the same amount of nourishing material is brought to the injured atrophied limb as in a condition of health; and now, as by the muscular atrophy a decided diminution of the needs for material occurs, an excess of nourishing material is present, and these passing to the account of the skin and the epidermoid tissues, the latter become hypertrophied.

EPILEPSY FROM GUNSHOT-WOUND, AND CURE BY OPERATION.—In a gunshot-fracture of the lower thigh (*Allgem. Med. Centralztg.*, No. 53, 1871), at the time of cicatrization epileptic attacks occurred. Three months later the patient came under the hands of Dr. Marten. The attacks had meantime continued uninterruptedly several times a day. The fracture was already consolidated; at two points, however, there were fistulæ leading to a fissure in the bone at the point of fracture, in the interior of which some loose fragments of bone were recognizable. The fractured bone between the fistulæ was removed, and the cavities were cleared out. During some weeks the attacks still appeared, in a much milder form, and then absented themselves entirely.

ON A NEW METHOD OF ARTIFICIAL RESPIRATION WITHOUT TRACHEOTOMY.—Horvath, of Vienna (*Centralbl. Med. Wiss.*, No. 50, 1871), says that in all physiological experiments for the production and continuance of artificial respiration, until now, tracheotomy and the introduction of a T-shaped canula, etc. have been taken for granted. We thus see how closely artificial respiration has been connected with tracheotomy, and how little other methods for the continuance of artificial

respiration without tracheotomy have been employed, although they have been long known and recognized as among the means of restoring animation. In the author's experiments with chilled animals he investigated, among other means, artificial respiration for the purpose of sustaining life, and also employed tracheotomy. In order, however, to obtain the isolated effects of cold upon the animals without any possible commingling of results, he sought a new method, and attempted to effect respiration by means of a catheter introduced into the trachea. After repeated experiments, the author hit upon a new method of producing artificial respiration without tracheotomy or any injury to the animals, and by this simple method to retain the animal alive. In one case in the country, in the absence of any of the necessary apparatus, he insufflated air simply by means of an air-bladder with a flexible tube inserted into the nasal passages. After each insufflation and consequent rising and sinking of the belly it appeared that the lungs distended themselves, and that artificial respiration could be thus effected. It was subsequently tried with success upon other animals.

The method is very simple, and is as follows: A short india-rubber tube, as thick as the finger, is connected by one end with the air-bladder and by the other is fixed upon the nasal openings so that the extremity of the tube as nearly as possible covers the nasal openings, and then the air is insufflated. The mouth at the same time is more or less open. The surplus air which does not reach the lungs escapes by the mouth, which thus provides against any possible rupture of the lungs.

The author further took a medium-sized rabbit, so fully curarized that it was entirely motionless, showed no reflex corneal sensibility, and the most powerful current through the ischiatic nerve produced no muscular contractions. Thereupon this plan of artificial respiration was employed, and it succeeded in retaining the animal in life with energetic cardiac contractions for fifty-four minutes. The same favorable results were obtained in a strongly-curarized dog for the space of one and one-third hours, and in a guinea-pig for twenty minutes.

All the animals were kept alive as long as the artificial respiration was employed, which was interrupted after from twenty to forty-five minutes because that time appeared sufficient to demonstrate the feasibility of the new experiment. Finally, as a proof of the deep curarization of the animals, they all died without convulsions.

In the absence of tubes of proper shape and size, the author used on one occasion a glass funnel, whose broad opening was then affixed to the nasal openings with the same effect upon the respiration.

It was observed in one case in a dead guinea-pig, that the cavity of the chest did not expand with strong insufflations, in proportion to the latter, and the *alae nasi*, instead of distending as usual, collapsed. It appears, therefore, that neither the one change nor the other is needful in the process to make it universally feasible. As many cases are now known in which the induction of artificial respiration is the only remedy, and yet in the want of a physician or of suitable apparatus it cannot be resorted to, it is to be wished that this method will be used in human subjects.

The occurrences of a recent period, where, from the want of artificial respiration, persons have died in the presence of accomplished surgeons, or where the patients have paid with their lives for the momentary hesitation of the surgeon as to whether tracheotomy should be performed or not, or where the operation has been commenced on the living patient and has ended on the cadaver,—all these prove clearly the necessity for a good method of artificial respiration, and have induced the author to announce the results of his method.

NOTES OF HOSPITAL PRACTICE.

UNIVERSITY OF PENNSYLVANIA.

SERVICE OF DR. GEORGE STRAWBRIDGE,

JANUARY 18, 1872.

Reported by Dr. CHARLES B. NANCREDÉ.

DR. STRAWBRIDGE stated that this clinic would be occupied by the consideration of some common affections,—viz., obstructions of the lachrymal apparatus. These are frequently met with, and are quite as frequently troublesome cases to treat. Formerly such affections were so poorly understood, and the variety of treatment recommended and practised was so great, that all operative interference fell into disrepute. Now we are able to treat these troubles very successfully. A few words must first, however, be devoted to a description of the anatomy of the lachrymal apparatus, before we can properly understand the treatment of its diseases.

First, then, we have the lachrymal gland, with which, in the present connection, we have but little to do, and which resembles any other racemose gland. It is situated between the superior and external recti muscles, in a depression of the external angular process of the frontal bone at the superior external angle of the orbit, being in relation by its inferior surface with the eyeball, by its superior with the frontal bone. This gland supplies most of the tears, although probably not all, since the conjunctiva would seem to be also a source of this secretion. The tears reach the surface of the eye by six or seven short ducts. Now we come to the portion of the lachrymal apparatus which most interests us at present, and we divide the parts into—first, the puncta; second, the canaliculi; third, the sac; and fourth, the duct. The puncta we can best see, by looking either at our own eyes in a glass or at those of a friend, as little black spots at the internal angle of the lids, brought into view by slightly everting them. These openings lead us into the next portions, called the canaliculi, by means of which the tears are conveyed from the surface of the globe into the lachrymal sac. They are very small canals, lined by a delicate membrane. In the diagrams we see them represented and their course shown. Taking, for instance, those of the lower lids, we see that at first their course is directly downwards for about one-half a line, when it forms an abrupt angle and runs slightly obliquely upwards and inwards to the sac, which we must next examine. This is composed of a fibro-elastic coat lined by mucous membrane, continuous above with the conjunctiva by the canalicular lining, below with that of the nose. It is about two lines in length, one line in breadth, and two and a half lines in its antero-posterior diameter. Now we have arrived at the last and, for our present purpose, most important portion,—viz., the duct, which extends from the sac above to the inferior meatus of the nose below, and is about an inch in length. Its course is downwards, backwards, and slightly outwards, varying in this last respect according to the width of the bridge of the nose,—a fact worthy of note, since it gives us some clue as to the direction in which to push our sound when once entered. The broader the bridge, the less is the inclination outwards. This duct is a bony canal lined by mucous membrane, its walls being formed by the superior maxillary and lachrymal bones, the latter being very thin; so that it will readily be seen how easily, unless care is exerted, the bone may be perforated. This accident is especially liable to occur in dilating dense fibrous strictures, or where there is calcareous deposit.

One of the most common affections of this portion of the ocular apparatus is that usually denominated "watery eye," or, technically, epiphora, in which the tears flow over the cheek. Now, of course this latter condition may obtain in a number of diseases,—such as phlyctenular ophthalmia, keratitis, conjunctivitis, etc. In these cases it is due to the irritation of the ciliary nerves, which is reflected to the gland, causing a copious flow of tears. Sometimes, too, this overflow may be owing to the presence of foreign bodies in the eye; of course this is not what is meant by epiphora. When, however, without any of these causes being in operation, we find the watery overflow chronically present, in many cases causing irritation of the skin of the cheeks by the constant maceration,

and even, in some cases, producing eczema, we are warranted in calling this epiphora. In degree it varies from a slight excess of the natural secretion to the worst condition described above.

What is to be done for such cases in the way of treatment?

First, a trial should be made of astringent applications, such as the "yellow wash" mentioned at a previous clinic, containing sulphate of zinc, muriate of ammonia, etc., or one composed of zinc alone. If these do not produce the desired effect, open the canaliculus with a Weber's knife, which is to be preferred to the old plan. This knife is probe-pointed, slightly curved, about five lines in length, and one line at its widest part. The point is generally made too large by the instrument-makers, so that it will not enter the punctum. The instrument is to be introduced into the punctum with its point directly downwards for about half a line, then turned at a right angle, or a little more, and pushed on towards the sac, keeping close to the anterior wall of the canaliculus until the point touches the bony wall, when by merely elevating the handle, while the lower lid is kept tense by the fingers of the other hand, the operation is completed. In the old method of performing this, first the canaliculus had to be dilated, then a director introduced, and finally the incision made by passing either a blunt-pointed pair of scissors or a knife along the groove,—thus in reality making three operations, and in the end not doing the work satisfactorily. (A patient was then introduced, upon whom the operation was performed.) By this little operation a larger opening is offered for the passage of the tears, which will generally suffice for the cure of the epiphora.

Now we must consider dacryocystitis, or inflammation of the lachrymal sac, which is the most common cause of stricture of the duct. We first notice a considerable, sometimes immense, tumefaction of both lids, after which a slight prominence appears at the inner angle of the orbit, that continues to increase until about the size of a pigeon's egg. The pain in this affection is oftentimes very intense, in consequence of the unyielding nature of the walls of the sac. In three or four days, the tumefaction steadily increasing, a yellow spot appears at its summit, showing that suppuration has occurred. Pressure now will often empty it of the pus, part passing out on to the surface of the globe through the canaliculi, part into the nose through the duct. The best treatment consists in the application, for a couple of hours three times daily, of hot chamomile-tea, to hasten the suppuration and relieve the swelling. When it points, an incision should be made and the pus thoroughly evacuated. Its reaccumulation should be prevented by keeping the wound open for a time, if necessary.

The best plan of treatment, when this lasts several weeks and becomes chronic, is unquestionably dilatation of the duct after slitting up the canaliculus, followed by the use of astringent injections. For this dilatation Bowman's sounds should be used, which are of six sizes. We need never go beyond No. 4. Now, how are these to be introduced? In this little operation the advantage of being ambidextrous is very great, for then we can sit opposite to our patient no matter which eye is affected. Having seated ourself facing our patient, the sound is to be introduced into the slit-up canaliculus, keeping close along its anterior wall until we meet with bony resistance, for then we are in the sac, touching its opposite bony wall. When this point is reached, the direction must be changed by carrying the handle directly upwards until it rests against the frontal ridge. To gently press the instrument down along the course of the canal is all that is now necessary to complete the operation. This is more difficult to explain than to do. If we doubt that the instrument has traversed the whole extent of the canal, we have only to pass another into the anterior nares, when we should feel the point about one and a half lines within the nostril. The sound should not be passed every day,—every other day, at the oftenest, being sufficient. The effect of this treatment is the widening of the duct. After using the sounds for three or four weeks, astringent injections are to be advised, by means of Anel's syringe, which is merely a small instrument of this description with a long removable point, this latter being in reality a hollow Bowman's sound. In using it the point is to be introduced first, part-way down the duct, after which the syringe is to be attached.

The clinic was closed by showing a number of cases of phlyctenular ophthalmia, introduced, Dr. Strawbridge said, principally because they were difficult ones to examine.

THE LOCAL TREATMENT OF HYPERTROPHIED TONSILS.—

Dr. B. Frankel read before the Berlin Medical Association (*Wiener Medizinische Presse*, February 11, 1872) an interesting communication on this subject. He said that in cases in which, from any cause, it was inexpedient to remove the tonsils by the knife, we must have recourse to one of two classes of remedies. 1. Caustics. Of these, he agrees with Prof. Lewin in preferring chromic acid. This should be applied in fine crystals (*Nadeln*) directly to the tonsils. Its application gives rise to little or no pain, is without danger, and produces a considerable reduction in the size of the glands. If great care is not taken, the surface of the tonsils will, however, acquire a lobulated appearance, inasmuch as those parts which have not been reached by the caustic will be unchanged and appear as ridges among the shrivelled portions. Dr. Frankel has, consequently, recourse to—2. Sorbefacients. He has found but little effect produced either by the application of the tincture of iodine by means of a camel's-hair brush directly to the part, or by the use of a solution of iodide of potassium and the atomizer, and therefore recommends that the iodine should be brought immediately in contact with the hyperplastic tissue. To this end he has made use of submucous injection of iodine, which he has never found to fail in appropriate cases. He prefers the solution of iodine in glycerine, as the alcohol in the tincture has a tendency to dissolve the cement with which the glass point of the syringe is fastened to the caoutchouc cylinder. The injection should be made in the following way: The tongue of the patient is to be depressed with a spatula, which should be held in the left hand of the operator, while with the right hand he introduces the point of the syringe into the tissue of the tonsil. So much of the contents of the syringe are then to be injected as may seem to be desirable. No pain is caused during the injection or afterwards, unless the instrument has penetrated into the surrounding muscular tissue. There is generally little or no hemorrhage. Care should be taken that the point of the syringe does not enter one of the numerous crypts of the tonsils. This may be known to have taken place whenever the iodine-solution is seen flowing out of the mouth of such a follicle. The injection may be repeated at the end of eight days.

A marked diminution in the size of the tonsil will frequently be observed after the first operation; but to arrive at definite results—i.e. to reduce the gland to the third or the fourth of its original size—it is sometimes necessary to repeat it from twenty to thirty times.

In some cases he also recommends the introduction of small pencils of iodine and iodide of potassium, made up with dextrin, into the mouths of the follicles of the tonsils.

In the discussion which followed the reading of this paper, Prof. Lewin spoke of the great relief afforded by the submucous injection of morphia in acute tonsillitis. The pain is at once relieved by it, and deglutition becomes possible.

THE USE OF NITRATE OF SILVER, IN CERTAIN LOCAL INFLAMMATIONS.—Mr. George Cowell (*The Practitioner*, February, 1872) recommends, in the treatment of swelled testicle and carbuncle, the application of the solid stick of nitrate of silver to the skin. In the case of testitis the skin covering the swelled testicle is to be drawn tightly, and, after being moistened with water, is to be freely rubbed with the nitrate of silver. Pain, he says, disappears in from two to six hours, and this is accompanied and followed by a gradual diminution of the swelling.

The *modus operandi* of the application of nitrate of silver in these cases seems to be the energetic stimulation and consequent contraction of the capillaries and small arteries of the parts, whereby engorgement is diminished, the vessels are placed in a condition for returning to a healthy function, and morbid exudation is diminished and removed.

A REMEDY FOR VARIOLA.—Dr. W. Marsden, of Quebec, writes to *The Medical Record*, February 15, to recommend the administration of the balsam of copaiba in the treatment of smallpox. Three drops are to be rubbed up with a little albumen, or mucilage and syrup, and administered three times a day. In a solitary case in which he used it, it acted like a charm, literally arresting the process of pustular development and consequent desquamation, and suspending the disease, leaving not a trace behind, nor a solitary unfavorable symptom, any more than if the patient had not been affected by smallpox.

PHILADELPHIA MEDICAL TIMES.

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EDITORIAL.

THE TIME HAS COME.

THERE are, in this country, few reflective teachers of medicine who are satisfied with the existing system of instruction. Yet he might perhaps be considered thoughtless who should advise the immediate introduction of the methods adopted on the continent of Europe simply because they are intrinsically the best, or afford the means of securing the most thorough education to the medical student. There are many reasons why the latter method is not available to us. Prominent, however, are the demands of the nation, which cannot afford to wait seven years for the education of its doctors, and the deficiency of endowed professorships, with the consequent necessity to teachers of some other source of income than teaching itself. Essentially, private practice becomes that additional source, and in its successful pursuit all know how completely time is absorbed, leaving the subjects of the professorship to be cultivated at odd intervals, and limiting the period of intercourse between teacher and student to a single hour, three or at most four times a week.

The question as to how endowments are to be obtained, or whence they are to come, is irrelevant here. It is sufficient that they do not exist. Nor have we to do with those exceptional cases where an inherited fortune permits its possessor some latitude of action. It is, however, clear that, in consequence of deficient endowment, the union of medical practice and medical teaching, even in what are called the non-practical branches, is essential in America at the present day, and is likely to continue so for some years longer.* It is only very recently that such separation has become possible in London, where the opportunities for obtain-

ing a thorough medical education, it is acknowledged, are vastly superior to any offered in this country. Yet even there the opportunity recently afforded to Burdon-Sanderson, Klein, and Brunton would appear to have been an almost accidental one. Admitting this proposition, however, the important question remaining for consideration resolves itself into one as to the possibility of improving the system of education, even with our present facilities. Our answer is unqualifiedly affirmative. Indeed, we will go further. We hold that not only is it possible to improve, but also that the time has come when to fail to do so is prejudicial to the best interests of the student and of the profession, and to the schools themselves.

With regard to the first, no effort at proof is required. There is no one who has been in the habit of examining students for a degree who can fail to blush when he is asked as to whether the qualifications of the average medical student are such as would make him willing to place a member of his own family under the care of such recent graduate.

That such a condition of affairs is prejudicial to the best interests of the qualified practitioner is plain from the fact that, owing to the deficient education of physicians,—at least as a professional body,—we are in danger of losing that respect which should be extended to the learned professions, while the community, having almost ceased to discriminate between empiricism and rational practice, are, in an alarming number of instances, as ready to intrust themselves to the charlatan as to the educated practitioner. Indeed, it is well known that the former often becomes rapidly wealthy, while the latter will struggle on for years, harassed and embittered by the privations of poverty, until, even when a competence is finally obtained, he is only fit to sympathize with a few choice spirits whose experience has been similar to his own. Society knows him not at all.

It is more difficult, however, to convince college management of the necessity of immediate reform, regardless of consequences, in our plan of medical education. For it is certain that such a radical change as would be required will primarily reduce the income of teachers by increasing the expense of conducting schools, as well as by diminishing the number of pupils. Nor do we think it would be wise to adopt any changes with the expectation that, even ultimately, the income to individual teachers will ever be as great as it once was in Philadelphia. For to secure that close personal relation of teacher and student which is demanded, one of two things is necessary: either the number of students under the direction of a single individual must be diminished, or the proportion of instructors must be increased. But whether the decided pecuniary loss which must be expected to attend reform in the early period of its institution be permanent or not, will depend largely upon the efforts of its instructors,—not simply upon the extent to which they offer facilities, but also upon the fidelity with which they carry them out. Earnest students will not be long in learning where the most thorough instruction can be

*There is, however, at least one branch—that of chemistry—in which such union has been found impossible even in America. And yet, strange to say, in some of the oldest and most successful schools in the country there is no recognition whatever of the principle which grows out of it, that this chair should receive a larger proportion of the fees; the additional sum sometimes paid to its incumbent for performing the duties of Dean being quite inadequate to make up the deficiency resulting from the almost total absorption of time by the duties of his chair. Moreover, it may sometimes happen that the Professor of Chemistry is not the most suitable person for Dean. These remarks occasionally apply to the Professor of Physiology; although he has usually a better opportunity for obtaining private practice, and there is a certain amount of good reason, indeed, why such Professor should be a practical man.

obtained, and will be found willing to assume the additional expense.

A moment's consideration, however, will satisfy us that the pecuniary loss will not be proportional to the reduction in the number of students attending. No one can expect that a term of instruction extending over ten months in a year, and conducted by at least twelve professors, with additional demonstrators, can be carried out for the same sum as one of four months by seven professors and two or three demonstrators. Two hundred dollars a year, or one hundred and twenty per session, as adopted by the management of the Harvard Medical School, would perhaps be a minimum; at this rate one hundred students at two hundred dollars each would return the same income to a college as one hundred and forty-two at one hundred and forty dollars each; while the expenses of a summer term would be greatly less than those of the winter, on account of the diminished consumption of fuel and light.

Moreover, the very fact that in American colleges the professor and practitioner are combined, affords us a means of surmounting this acknowledged obstacle to reform. As a consequence of this union, very few professors in our medical schools are dependent upon their professorships for a livelihood. They are generally in a practice which alone will support them. No one, however deep his enthusiasm, could be asked to support his family upon expectations while he was laboring to build up an improved system of medical education. Fortunately, however, what, considered from some points of view, is a disadvantage, makes such an alternative unnecessary, and takes away any valid excuse for longer delay.

Supposing it admitted that a change in the mode of instruction is demanded, the next question is as to the manner in which such modification should be made. This can be arrived at only by careful deliberation. It has already been stated that the adoption of the German plans would scarcely be wise, if at all possible, at this stage in the history of American medicine. But there is still to be obtained the golden mean which will be adapted to the state of civilization in this country. In general, the mode of instruction at the English hospitals would rather become the model, and, to come nearer home, the plan of the Harvard Medical School seems to embody the germ of a system which is quite within our reach. Details must be left to deliberation and circumstances. But the desiderata are primarily an extension of the term of study, in order that students may not be compelled to attend from six to nine lectures daily, on different subjects, for four months, but that, by attention to three or four departments at a time, they may acquire a sufficient mastery to enable them to pass a satisfactory examination at the end of the year; and in which, having satisfied their instructors, they may pass in a second year to more advanced studies, and thence to a third, which will include what are known as the more practical parts of their curriculum,—clinical medicine, clinical surgery, practical obstetrics, and diseases of women. To be enabled to do this, not only must the

period of study be lengthened and graded, but the number of instructors must be increased, particularly in the practical departments, upon whose courses attendance should be compulsory, and who should have a voice in testing the qualifications of the candidates for graduation. Any extension of facilities to students which must increase the number of hours of daily labor is of questionable propriety. To make attendance upon them compulsory would be cruel to the student, and to make them elective by those who choose to take advantage of them will result in their being attended by a few only. By extending the period of study, however, and properly grading the course, full advantage can be taken of extended facilities, while those engaged in teaching the additional branches will feel encouraged to enthusiasm and more careful effort. Not until the period of study is extended, then, will the very desirable professorships of Clinical Medicine, Clinical Surgery, Pathological Anatomy, Diseases of Women and Children, Dermatology, and Ophthalmology, become available.

Among special modifications desirable, none is more so than that which will make chemistry, physiology, histology, and pathology the subjects of laboratory-teaching. Lying at the foundation of medicine, it is a superficial knowledge of these more than of anything else which is the cause of the digression we too often see among graduates of American colleges from the paths of rational medicine to those of empiricism.

We reiterate that the time has come for reform. Let there be no hesitation on the part of one school because another hesitates to take the step simultaneously. Indeed, this disposition to delay improvement until another has taken a similar step has been a constant obstacle to a true progress in medical education. Apart from the inherent obligation which is binding upon institutions as well as individuals, and which commands progress, the college which is the first to make the change will be the first to reap the advantage, though she may be the first also to suffer temporary disadvantage and embarrassment. Certain it is that to-day the cream of medical students—those whom every institution is most anxious to have enrolled upon its list of matriculants—assemble in a medical school which only a few years ago was considered third-rate, but which has now suddenly leaped into the first position in the country, although located in a city which is signally deficient, as compared with New York and Philadelphia, in clinical and pathological material.

But a few days ago the president of the most justly famous university in the country spoke of the medical as a "profession which was once called learned."* Mortifying as it is, we must admit a certain amount of truth in it. Let Philadelphia, so long the acknowledged centre of American medical learning, not be laggard in making an effort to erase the blot upon our escutcheon. Suppose the number of graduates annually to be small: such a fact must add to, rather than detract from, the reputation of a first-class medical school, if the few who

* Annual Report of President Eliot, of Harvard University.

are graduated be thoroughly educated. And when, later, it shall be known that to be one of that annual few secures respect and insures success, there will be no uncertainty as to the future of the institution they fondly call Alma Mater.

CORRESPONDENCE.

THE CASE OF PROTRACTED GESTATION.

TO THE EDITOR OF THE PHILADELPHIA MEDICAL TIMES.

IN your journal of January 15, 1872, I reported a case entitled "Protracted Gestation and Labor complicated with Puerperal Convulsions." At the end of the article a short editorial notice was added, in which a doubt was expressed whether the case was one of protracted pregnancy. I will simply give a short history of the case.

Mrs. K., as reported, was regular up to the 20th of November, 1870; in December, 1870, about the time she expected to be sick (which was near the holidays), she was expecting some company from New York. At this time she made the remark to her mother "that it was too bad, just as she was about to entertain her company, she was going to be sick, and that it would interrupt her pleasure." She prepared for the occasion. The time came, but with it no sickness. In a few days morning sickness set in. Her mother, thinking that her daughter had caught cold, put her on tansy tea, oil of tansy, mustard hip-baths, etc., for over a month. The only effect these had, was to make the patient extremely weak.

I do not doubt myself that the case was one of protracted gestation, and that impregnation took place soon after her last sickness in November, for shortly after she was taken with sick stomach in the morning, and partook of things which when in her usual health she did not care for. She first felt the movements of the child about the first days of March, which, counting from November, makes four full months.

On the 17th of September, 1871, the patient was taken with labor-pains, which lasted all night, gradually disappearing towards morning, after which she continued well (with the exception of the anasarca condition which set in on October 20) up to the time her labor set in, on October 30, three hundred and forty-four days.

The appearance of the child would also go to prove prolonged pregnancy. The child was enormous: its size and weight I have already given.

I would also state that the mother of the patient once carried a child (male), which was born dead after a protracted labor, two weeks over her time.

EUG. P. BERNARDY,
905 Walnut Street.

PHILADELPHIA, March 20, 1872.

ALARMING SYMPTOMS FROM INJECTION OF COLD WATER INTO THE VAGINA.

TO THE EDITOR OF THE PHILADELPHIA MEDICAL TIMES.

IN your issue of 1st instant the case of Mrs. G., reported by Dr. A. K. Minich, with "symptoms of poisoning produced by the injection of a strong solution of sulphate of zinc into the vagina," reminds me forcibly of the following from my own practice.

Mrs. L., aged 36 years, suffering from chronic endometritis, had been using for some months cold-water injections morning and evening. There was prolapsus, and the cervical canal was quite patulous, admitting the extremity of the index-finger. The vaginal pipe of the syringe had in its extremity an opening which permitted a stream to escape directly forwards, as well as the lateral streams,—a faulty construction, I think, which I usually correct by closing up the terminal opening.

One evening during the past summer I was hastily summoned to her bedside, and found her presenting symptoms very similar to those described by Dr. Minich. I learned that she had used the syringe and cold water just before retiring for the night as usual, and that immediately afterwards she was seized with violent pain in the left iliac fossa, and was obliged to desist and to be lifted into bed.

I felt confident that the cold water had been thrown into the womb and a portion of it through the left Fallopian tube into the peritoneal sac. The faulty opening in the syringe-pipe was closed, and care enjoined that the pipe should not be passed into the os uteri. No similar accident has occurred since.

ROBERT BATTEY, M.D.

ROME, GA., March 14, 1872.

OBITUARY.

PROF. FREDERICK JÄGER.—This once distinguished ophthalmologist died recently at the age of eighty-eight, having outlived, it is said, his generation and his greatness; lying paralyzed and in comparative penury, a remnant of the past. He graduated at the University at Landshut in 1808, and also took his degree of M.D. at Vienna in 1818. Having soon afterwards made ophthalmology a special subject of study and practice, he was appointed to examine into the peculiar circumstances connected with the prevalence of ophthalmia in a portion of an important military command stationed on the Austrian frontier. He was next appointed Professor of Ophthalmology in the Josephinum Military Hospital, and here he gained reputation and honors which insured him an immensely remunerative private practice and the esteem and friendship of the educated and refined of his country, especially of Metternich, the prince and diplomatist. Vienna was the field of his professional exploits, and the scene of his many surgical triumphs in affections of the eye; but, his hand once paralyzed, and the labor thus passing to other surgeons, that great city soon forgot its favorite ophthalmologist, and he died in straitened circumstances, although his lavish expenditures had much to do with this result.

DR. GEORGE E. DAY.—This celebrated physician and medical writer died in England January 31, in his fifty-seventh year. He studied medicine at Edinburgh, taking quite a number of gold and silver medals and other prizes, and becoming the friend of men like Goodsir, Forbes, and others of that time. He was a martyr through many years to disease and to the results of a severe accident; yet he accomplished an amount of literary work that few of those endowed with perfect physical organization could attain. His knowledge was voluminous and his industry illimitable. His best-known works are "The Diseases of Advanced Life," "Chemistry in its Relation to Physiology and Medicine," a translation of Simon's "Animal Chemistry" and Rokitsansky's "Pathological Anatomy" for the Sydenham Society, Lehmann's "Physiological Chemistry" for the Cavendish Society, and the greater portion of the medical articles embraced in Chambers' Encyclopædia. "Few who read the reviews and scientific notices in our own columns," says the *Medical Times and Gazette*, "could have surmised that they were written by an invalid disabled by ununited fracture of one arm, helpless

upon the legs, and distracted by a host of minor sufferings arising out of his state of rheumatism and prostration. Almost up to the last he retained his habit of literary work."

DR. HENRY D. BULKLEY.—The name of this gentleman, who died recently in New York at the age of sixty-seven, is better known to the profession at large as the translator and editor of Cazenave and Schédel on "Diseases of the Skin," than for those personal qualities which made him prominent and popular among his professional brethren in that city. During his whole career he made the study of cutaneous affections a specialty, on which he at one time lectured at the College of Physicians and Surgeons. He was at different times President of the County Medical Society of New York and of the Academy of Medicine, and editor of the *New York Medical Times*. He was a learned and skilful physician, honored for his integrity, and conspicuous for his zeal and industry in the pursuit of his profession.

PROF. C. A. LEE, M.D.—The subject of this notice, who died about the middle of February, in his seventy-third year, was well known as having held professorships in a number of the prominent medical schools of the country. Among these may be mentioned the Medical College of the University of New York, those of Buffalo, Geneva, and Woodstock, and the Bowdoin and Berkshire Medical Schools. But he was perhaps still more widely known for his contributions to medical literature. He edited the American edition of Dr. Copland's valuable "Dictionary of Medicine," was the author of a work on Physiology, and was at one time the editor of the *Journal of Medicine* of New York.

PROCEEDINGS OF SOCIETIES.

PATHOLOGICAL SOCIETY OF PHILADELPHIA.

THURSDAY, FEBRUARY 21, 1872.

THE PRESIDENT, DR. J. H. HUTCHINSON, in the chair.

DR. MÜLLER exhibited a specimen of *occlusion of the pericardium*. The heart was removed from W. M., æt. 64, a farmer, born in England, who was admitted to the Germantown Hospital on January 18, 1872.

All that could be ascertained of his previous history was that he had been injured while clearing land in Michigan, and that he had suffered much with shortness of breath, so that he was considered asthmatic. On admission he presented a strikingly blanched appearance; his tongue, gums, and teeth were dry, and covered with sordes. Breathing was stertorous, and so loud as to mask the heart-sounds. The pulse was 120, and extremely weak. There was dulness on percussion, and absence of respiratory sounds on the right side of the thorax. His urine was abundant, not albuminous, and voided for the most part involuntarily, as were also the feces three or four times a day. The comatose condition in which he was first seen, continued up to the time of his death, February 8.

Autopsy.—*Thorax*: The left lung was collapsed, firmly adherent; the pleural cavity contained about two pints of serum. The right lung was healthy. The heart was dilated. All the valves were more or less insufficient. The pericardial sac was completely occluded.

Abdomen.—The liver was very fatty. The kidneys were about normal in size, and showed on section some slight fatty degeneration. The spleen was enlarged to thrice the normal size, and filled with black blood. The stomach and intestines were healthy.

The brain was not examined.

DR. JOHN S. PARRY exhibited a specimen of *primary cancer of the vagina*, removed after death from a woman who was the mother of three children. She was in good health until July, 1871, when she applied to Dr. W. F. Jenks, at the Obstetrical Department of the Philadelphia Dispensary, on account of a profuse hemorrhage. He found a tumor between the vagina and rectum which was hard and ulcerated. A little later she was admitted to the Philadelphia Hospital, exhibiting

no cachexia whatever. Soon after admission, hemorrhage set in, and the induration spread from the posterior and lateral parts of the vagina to the rectum. By November, 1870, ulceration had progressed so far as to have destroyed the posterior part of the vagina and produced a communication between the vagina and the rectum.

At the autopsy all the organs in the pelvis were found more or less diseased. But a curious feature is that the uterus was scarcely at all involved. There was some ulceration posteriorly about the os, but the body of the organ was healthy. The left Fallopian tube was adherent, and the fimbriated extremity of the right Fallopian tube contained a little abscess.

There was no evidence of acute peritonitis in any part of the abdominal cavity. The bladder was perfectly healthy, except that it was somewhat congested. The ureters were normal, except that the right was somewhat smaller than the left; it traversed the indurated mass, but was patulous. There was no carcinomatous disease in any of the other organs.

DR. JAMES TYSON presented, for Dr. H. C. WOOD, the following specimens:

1. *Caries of the cervical vertebra* from a syphilitic patient;
2. *Softening of cerebrum and cerebellum*.

DR. TYSON also presented a specimen of *extensive atheromatous disease of the aorta*.

BIOLOGICAL AND MICROSCOPICAL SECTION OF THE ACADEMY OF NATURAL SCIENCES.

MONDAY, FEBRUARY 5, 1872.

DIRECTOR W. S. W. RUSCHENBERGER, M.D., in the chair.

Present, twenty members.

DR. HENRY C. CHAPMAN made some interesting remarks upon the subject of Embryology, illustrating, by means of numerous colored drawings, the formation of the three blastodermic membranes which subsequently give origin to the integument, bones, etc., and also explaining the development of the eye and other special organs. This communication will probably appear in a future number of the *Philadelphia Medical Times*.

DR. J. H. MCQUILLEN directed attention to the deposition of tartar or salivary calculus, in large or small quantities, around the necks of the teeth, the accumulation being most extensive on the teeth in the immediate neighborhood of the salivary ducts. Writers had divided it into different varieties,—hard and soft, white, yellow, brown, and black. The differences, however, were simply due to whether it was a recent or an old deposit, and the absence or admixture of coloring-matter. The inorganic constituents were mainly phosphates and carbonate of lime and magnesia, combined with mucous, saline, and animal matter. Of its origin—every article of food taken into the mouth, vegetable or animal, contains certain proportions of the salts of lime, magnesia, potassa, soda, etc.; and these can be found in the blood, being there mainly for nutrition of the bones and teeth. An illustration of this is made markedly manifest in the repair of bones and the rapidity with which the provisional callus is formed,—uniting the fractured ends of a long bone like the humerus or femur so that splints can be dispensed with in from six to eight weeks. In the ordinary nutrition of the bones and teeth the excess of these salts present in the blood is removed from the system through the various secretions. Occasionally, owing to their becoming insoluble, they are arrested in their passage through the different channels, and accumulations take place at certain points; thus, biliary calculi are found in the gall-bladder and the ducts connected with it, urinary calculi in the kidneys and bladder, chalk-stones form in the joints, and calcareous accumulations occur in the brain.

A large proportion of the salts passes through the salivary glands, and is deposited around the teeth. It is fair to infer, therefore, that salivary calculus originates from this source. It has, however, been suggested by some that, like the coral islands and chalk cliffs, it has its origin in infusoria. Recently, on making some examination of the salivary calculus and decay removed from teeth, Dr. McQ. had been interested

in the movements of a number of microscopical objects. In consulting the various works in his possession, he had been somewhat surprised to find that no reference was made to this matter either in the *Micrographic Dictionary*, Quekett, Carpenter, Hogg, or Gosse. The only exception to this was a paper by Schrott, of Mühlhausen, Germany, translated by Dr. Adolf Petermann in the *Dental Cosmos*, vols. x. and xi., in which he describes a variety of vegetable and animal parasites observed by him in the saliva. Dr. J. G. Richardson, in his "Handbook of Medical Microscopy," also touches upon the subject. In his own observations he had invariably found, on placing recently-deposited tartar under the microscope, myriads of objects moving about in the saliva in the most rapid manner; these were of various forms bearing resemblance to the amœbæ, monads, vibriones, and spirilla, the latter being the least numerous. In certain portions of the field, where there were small patches of tartar, those that resemble the vibriones could be found entangled and projecting from them, and writhing as if they were endeavoring to escape from their position. In other patches, from which they had escaped, there was a honeycombed appearance somewhat like that found in brain-coral. He was by no means disposed to assume that the presence of these beings in the calculus was due to the fact that they were engaged in its formation, as they might have become imbedded in it.

In the decay removed from the teeth he had found a number of the so-called denticolæ; these in their appearance resembled the vibriones already referred to. The decay of teeth had been attributed by some to the presence and action of these beings; and while he was not prepared to deny that this was the case, as his opportunity for investigation had not been sufficiently extended to warrant him to express an opinion, it was reasonable to infer that they may have worked their way in after the teeth had become decayed.

REVIEWS AND BOOK NOTICES.

PULMONARY CONSUMPTION: Its Nature, Varieties, and Treatment; with an Analysis of One Thousand Cases to exemplify its Duration. By C. J. B. WILLIAMS, M.D., F.R.S., Senior Consulting Physician to the Hospital for Consumption, Brompton, and CHARLES THEODORE WILLIAMS, M.A., M.D., Oxon., Physician to the Hospital for Consumption, Brompton. 8vo, pp. 315. Philadelphia, Henry C. Lea, 1872.

ON THE TREATMENT OF PULMONARY CONSUMPTION BY HYGIENE, CLIMATE, AND MEDICINE, IN ITS CONNEXION WITH MODERN DOCTRINES. By JAMES HENRY BENNET, M.D., M.R.C.P., etc. Second Edition, 8vo, pp. 190. D. Appleton & Co., 1872.

As its title implies, Dr. Williams' work is a much more comprehensive treatise on the subject of consumption than that of Dr. Bennet. Its writer has evidently had, moreover, better opportunities for observing the disease under its various manifestations, for, in addition to having been a most successful practitioner of medicine in London, he has held several hospital positions, and has evidently used them for the purpose of acquiring a thorough acquaintance with the nature, course, and treatment of phthisis pulmonalis. Although he had in early life the benefit of instruction from Laennec, both at the bedside and in the dead-house, he did not adopt the very exclusive views of the great master, but ranged himself, with Andral, Alison, and Cruveilhier, on the side of those who maintained that phthisis occasionally was the result of inflammation. This opinion he has expressed in some of his earlier writings. In the preface to the book before us he says, "I believe pulmonary consumption to arise from a decline or deficiency of vitality in the natural bioplasm or germinal matter, and this deficiency manifests its effects not only in a general wasting or atrophy of the whole body, but also in a peculiar degradation—chiefly in the lungs and lymphatic system—of portions of this bioplasm into a sluggish, low-lived, yet proliferating matter, which, instead of maintaining the nutrition and integrity of the tissues (which is the natural office of the bioplasm), clogs them and irritates them with a

substance which is more or less prone to decay, and eventually involves them also in its own disintegration and destruction. This degraded bioplasm, which I will call phthino-plasm (wasting or decaying forming material), may be thrown out locally, as a result of inflammation, or it may arise more spontaneously in divers points of the bioplasm in its ordinary receptacles, the lymphatic glandular system; and then it commonly appears in the form of miliary tubercles, scattered through the adenoid tissue of the lungs."

In regard to this adenoid tissue, Dr. Williams says that there are in various parts of the body structures exactly resembling—in fact, identical with—that of the follicles of the lymphatic glands, and he believes that the tubercle-nodules which are found in the lungs in cases of miliary tuberculosis are really overgrowths of nodules which existed before. It is well known that Niemeyer and other German pathologists regard the form of disease originating in inflammation, and which they call phthisis pulmonalis, as by no means identical with tuberculosis, although the former frequently becomes complicated by the latter, and undoubtedly predisposes to it, but it has not yet been made very clear in what way. By Niemeyer it has been attributed to the direct infection of the blood in consequence of the absorption of the corpuscular elements of the caseous matter which characterizes phthisis, and which is supposed to give rise to extravasation of white blood-corpuscles in various parts of the lungs. Dr. Williams explains the supervention of tuberculosis by supposing that the presence of pus in any part, whether by production or inoculation, may have a deteriorating influence on the sarcophytes (leucocytes) of the blood and lymphatics, which may in their turn excite to hypertrophy the adenoid tissue which is found in various parts of the lungs, and in this way give rise to miliary tubercles.

The statistical parts of the work have been entirely confided to the author's son, Dr. C. Theodore Williams, and the chapters contributed by this gentleman "On Family Predisposition and certain other Causes of Consumption," "Hæmoptysis and the Hemorrhagic Variety of Consumption," "The Duration of Pulmonary Consumption," and on the treatment of consumption, will be found to contain much useful information. We regret that want of space prevents us from presenting our readers with an analysis of them.

In conclusion, we would say that the book is fully up to the times, and not merely contains a digest of the experience of an accomplished physician who has attained an advanced age in the practice of his profession, but shows that the author has a fair acquaintance with the writings of his continental contemporaries.

We cannot speak of the second book in terms of such unqualified praise. Dr. Bennet has, in one sense, certainly enjoyed unusual opportunities for the study of phthisis, for some years ago he was obliged to give up a lucrative practice in London to go to the south of France, in the hope that a change of climate would arrest the development of the disease in his own person. His treatment of his own case seems to have been judicious, and many of the rules which he lays down for the management of consumptive patients are excellent. His field of observation has, however, been limited by his change of residence, and his practice has been confined to the care of invalids who have, like himself, left their homes in search of health.

He regards all forms of phthisis as essentially the same disease, and dependent upon "a tubercular exudation in varied stages of development, from the gray or yellow miliary tubercle to the large cheesy or cretaceous masses," and says, in his preface, "I believe, also, that I am warranted in stating that most physicians of matured age and enlarged experience, who have given themselves the trouble to study this controversy, lean to the same side, and are indisposed to substitute the term 'chronic pneumonia' for that of 'chronic phthisis,' on the ground of long-continued clinical observation. On the other hand, most of the followers of the new 'inflammation doctrines' are young, enthusiastic physicians, full of knowledge, but deficient in experience." It would, of course, be interesting to know at what age enthusiasm ceases to exist and the powers of observation become keen. We certainly know of some physicians of mature age and of great clinical experience who are adherents of the new "inflammation doc-

trine," as Dr. Bennet calls it, although he cannot be ignorant of the fact that it is really not new, since it was professed long ago by the eminent physicians to whom we have already alluded in the course of this notice. It is therefore scarcely fair to say, as he does, that all those who are best qualified to have an opinion on this point are of his way of thinking. Nor do we think that the acceptance of the inflammation doctrines necessarily implies a change of the plan of treatment at present in vogue. Every author with whose works we are familiar recognizes that there is a constitutional condition behind the local one calling for supporting measures. Even Niemeyer's treatment can scarcely be called depleting, and the advice which he gives to keep the patient quiet when there are evidences of much pulmonary irritation might, we think, be followed with advantage by others. Dr. Bennet's treatment of his own case could with as much propriety be called antiphlogistic. Unless we misunderstand what he has written, he believes that the acceptance of the theory which he condemns brings about different results in the physician and the patient, the former becoming excessively anxious to protect his patient from all sources of irritation, the latter extremely reckless in exposing himself to them.

The chapters on the treatment of consumption by hygiene, climate, and medicine contain the suggestions of a physician who has made the climate of the shores of the Mediterranean a careful study; and the last chapter in the book, entitled "What are Cured Consumptives to do in Life? Can they Marry?" will be found well worthy of an attentive perusal.

MODERN MEDICAL THERAPEUTICS; a Compendium of Recent Formulae and Specific Therapeutical Directions. By GEORGE H. NAPHEYS, A.M., M.D., etc. Third Edition. 8vo, pp. 496. Philadelphia, S. W. Butler, M.D., 1871.

This volume, as its title-page expresses, consists of a large number of prescriptions, accompanied with directions, both as regards the use of the remedies and the diet and general hygienic treatment of the patient.

The author has drawn largely from Aitken's Science and Practice of Medicine, and many other works of similar character, and also from the *Lancet* clinical reports, the English Hospital Reports, etc.

Thus we see that all that is in the book is valuable. But the work labors under the same difficulties which embarrass the various school compendiums: it is necessarily brief, and its conciseness deprives it of value.

A foot-note refers the reader to the source of each extract, and thus this work accomplishes the object of an Index Rerum on therapeutics. If the course on materia medica and therapeutics in our medical colleges were a practical one, if every student performed for six months the duties of a pharmacist, there would be no demand for such a work. Under the present system of medical education, the time given to the study of diagnosis is insufficient, but that devoted to the acquisition of an acquaintance, theoretical and practical, with the articles of the materia medica, the physician's tools, is entirely inadequate. The young physician makes out his case, but how shall he treat it? He generally treads in the footsteps of his preceptor, slightly modified by the modern teachings of his medical school.

The want of a knowledge of practical therapeutics is general even among the most laborious and best-educated members of our profession.

This want is supplied by study after graduation, by reference to our standard works on therapeutics, and by constant reference to the results of the labors of other minds as expressed in the various journals. But to the hard-worked country practitioner time is precious, journals are few, and money for books is not too plenty. Dr. Napheys presents to him a tempting volume, a cheap compendium which claims to contain just the knowledge of which he has felt the need, positive directions for treatment, sharply-drawn lines, no doubts, no hesitating.

That the want has been felt, and that this book has supplied the need, is evidenced by the simple fact that two large editions have been exhausted in little over a year. The book is undoubtedly good and useful; but its usefulness would be greatly enhanced by an increase in its size.

We cannot close this notice without calling attention to,

and expressing our disapproval of, the manner of writing the directions appended to the prescriptions. Great care has been given to the terminations of the names of the medicines, but the same care has not been taken in writing the directions. A few examples will show to what we refer. Prescription No. 88 (pills), "Three to be taken *ter die*." Prescription No. 90, "A dessertspoonful in water *ter die*." Prescription No. 91 (pills), "Two *ter die*." Prescription No. 94, after giving medicines and excipients, ends with, "Divide into XL. pills." Again, we find many prescriptions ending in this manner: "For ten pills," "For six powders," etc. These things may seem trifling, but they are incorrect and inelegant. We are all prone enough to become careless in little things, and our guideposts should set us good examples, and, to use an old and true proverb, "if a thing is worth doing, it is worth doing well."

TRANSACTIONS OF THE NEW HAMPSHIRE MEDICAL SOCIETY (Eighty-First Anniversary), held at Concord, June 6 and 7, 1871. 8vo, pp. 110. Manchester, John B. Clarke, printer.

The annual address was delivered by the President, W. H. H. Mason, M.D., who dwelt at length on the necessity of deep research in making a diagnosis, and of assisting our senses by the microscope, by chemistry, etc. He attaches great importance to the changes in the character of the urine consequent on disease, and illustrates by various cases the value of medical chemistry in detecting obscure diseases.

Dr. John Blackmer delivered the annual oration on the subject, "Our Duties with Regard to the Use of Alcohol," under which head he includes brandy, whiskey, wine, ale, cider, and beer. Much time and research have been bestowed on the preparation of his address. Dr. B. can see no benefit from the use of alcohol in any class of diseases; while he sets forth in strong colors the evil consequences that too frequently follow the loosely-given advice of the physician to "take a little wine."

The report on surgery, by George A. Crosby, M.D., of Manchester, is a paper of more value than the majority of its class. He calls attention, in the course of his remarks, to the "autoplastic treatment of severe burns," the character and treatment of carbuncles, the uses of carbolic acid, the operation of "tapping the urinary bladder," and fractured ribs of the insane, and closes with an account of some of the many curious results following injuries of nerves. Each article is concise and clearly written.

Next follows a paper by Henry M. Field, M.D., on "Relief of the Indigestions by the Use of Physiological Remedies." The remedies alluded to are, of course, pepsin, pancreatin, hydrochloric acid, iron, with tonics, and water enema.

Dr. G. B. Conn, of Concord, reports a case of "Pneumopericardium." Death occurred after ten or twelve hours' illness. The history of the case reveals but little from which to form a diagnosis. Age of the patient, 41 years; height, 5 feet 8½ inches; weight, 180 pounds. Habits intemperate. He was confined in a prison at the time of his death. Six weeks previous to this event, he was seized with a pain in his chest which was "like cramp;" another similar seizure occurred a few days later. Soon after these seizures became more frequent. During the attacks his surface was cold and pulse weak and fluttering. The man was taken from work, counter-irritants were applied externally, with antispasmodic medicines internally, and he was placed upon a light diet. An apparent change for the better followed; but death resulted from exhaustion, after an uneasy night. This exhaustion was the consequence of congestion of the lungs, with pulse 130, respiration 25 per minute, mucous râles, and frothy expectoration tinged with blood. A post-mortem examination revealed a congested lung without inflammatory signs. The pericardium was distended with air, which escaped with a hissing sound when a puncture was made. There were no signs of inflammation either recent or previous about the pericardium, endocardium, or valves. The article closes with extracts from the various treatises on Pathological Anatomy.

Dr. Wheeler, of Dover, contributes an interesting paper on the almshouses of the State.

Reports of delegates to the Rhode Island Medical Society and the American Medical Association, and obituary notices of John G. Parker, M.D., James B. Abbott, M.D., and William Lighton, M.D., are appended to the volume.

TRANSACTIONS OF THE MEDICAL SOCIETY OF THE STATE OF PENNSYLVANIA AT ITS TWENTY-SECOND ANNUAL SESSION, held at Williamsport, June, 1871. Sixth Series, Part Second. 8vo, pp. 280. Published by the Society.

The delegates were welcomed by Dr. Samuel Pollock, of Lycoming, in an eloquent address. The sittings of the society occupied portions of three days, and were relieved by a banquet, receptions, an excursion to Minnequa Springs, etc.

The address of the President, S. D. Gross, M.D., LL.D., of Philadelphia, was very interesting. It was delivered in the evening at the Academy of Music. The audience embraced many of the refined and cultivated citizens of Williamsport. The subject of the address was *physicians, their qualifications, failings, etc.*, and was well illustrated by anecdotes.

A statement, by Dr. A. H. Halberstadt, of his difficulty with the Schuylkill County Medical Society was received by the State Society and included in the transactions.

Dr. Laurence Turnbull read a report of *six hundred cases of disease of the ear*.

Dr. Benjamin Lee, of Philadelphia, read the history of a case of *thyroid dislocation of the hip-joint in the second stage of coxalgia*. It was reduced by manipulation.

The same gentleman exhibited a peculiar modification of Taylor's "spinal splint" for the relief of posterior curvature of the spine. The principle on which this instrument is constructed is to discard the crutch-head supports in the axillae, and to substitute for it pressure by means of padded plates, at and a little below the point of disease, thus preventing the opposition of the diseased surfaces.

Dr. T. H. Squire, of Elmira, exhibited his vertebrated prostatic catheter.

The reports of the county medical societies form a series of valuable papers, embracing notes on drainage, topography, geology, meteorology, mortuary tables, and prevalent diseases throughout the entire State for the past twelvemonth. From these we learn that epidemics of scarlatina ranged through large portions of the State.

The report from Philadelphia embraces an account of the epidemic of relapsing fever which occurred in that city, and also a complete record of the cases of yellow fever, imported and consequent, with maps and a succinct history of each case.

The death-rate of Philadelphia for the year 1870 was 2.27 per cent., which places it among the healthiest of cities. The total number of deaths was 15,317; of these 2308 were from phthisis pulmonalis. The death-rate for the year 1869 was 2.23 per cent. The death-rate for London for 1870 was 2.40 per cent., Edinburgh 2.60 per cent., New York 2.93 per cent., Liverpool 3.10 per cent.

BOOKS AND PAMPHLETS RECEIVED.

On the Physiology of Syphilitic Infection. By Fessenden N. Otis, M.D., Clinical Professor of Venereal Diseases at the College of Physicians and Surgeons, New York, etc. Reprinted from *The Medical Gazette*.

Clinical Observations on the Dementia and the Hemiplegia of Syphilis. By M. H. Henry, M.D., Surgeon to the New York Dispensary, Department of Venereal and Skin Diseases. Reprinted from *The American Journal of Syphilology and Dermatology*.

Third Annual Report of the State Board of Health of Massachusetts, Boston, 1872.

Practical Suggestions in Naval Hygiene. By Albert Leary Gihon, A.M., M.D., Surgeon United States Navy, etc. 12mo, pp. 131. Washington, Government Printing-Office, 1871.

GLEANINGS FROM OUR EXCHANGES.

THE DISTILLED WATER OF THE SEEDS OF THE LUCUMA MAMMOSA.—Dr. John C. Oxamendi (*Anales de la Real Academia de las Ciencias médicas, físicas y naturales de la Habana*), in the course of a communication to the Royal Academy of Medicine of Havana, calls attention to this preparation. He

says, "The almond enclosed in the fruit of the *Lucuma mammosa* (natural order Sapotaceæ), a tree well known in Cuba, where its fruit is extensively eaten, should have occupied long ago, in consequence of its medicinal properties, a prominent place in our indigenous materia medica, and might have been used with great advantage as a substitute for the distilled waters, which owe their medicinal qualities to the cyanide of potassium, and rarely to the prussic acid they contain." In consequence of the cherry-laurel water obtained from the United States being of poor quality, Dr. Oxamendi says the distilled water of bitter almonds, and, where this cannot be obtained, that of the *Lucuma mammosa*, should be preferred. The seeds of this plant are encased in a thick coating, which renders it possible to keep them for a long time without the occurrence of putrefactive change.

A bottle containing a small quantity of the distilled water was shown to the members of the Academy, and found to have the smell of hydrocyanic acid.

In regard to the therapeutical application of this remedy, Dr. Oxamendi says that it should be administered in those affections in which we wish to diminish an exaggerated pathological sensibility, manifested, directly or indirectly, by reflex action. Hence it has been recommended in cardialgia and vomiting. It is also used to allay coughing, but should not be prescribed in cases accompanied by fever or by profuse expectoration.

Little has been written in regard to the medical properties of this fruit. Descourtiz writes concerning it as follows: "The fruit before ripening possesses astringent qualities which make it useful in the treatment of cases of intestinal atony, and chronic diarrhoeas which have resisted other remedies are sometimes cured by it. The ripe fruit is slightly astringent, and will be found a useful addition to gargles in sore throat. The seeds are said to possess diuretic properties."

THE BATH IN SMALLPOX.—Dr. Stokes, Regius Professor of Physic in the University of Dublin, recommends in the *Dublin Journal of Medical Sciences* for January, 1872, the use of the warm bath in the treatment of smallpox. He says, "We cannot doubt that the mortality in smallpox hospitals would be greatly diminished by the use of the bath." After describing a very severe case of confluent smallpox in which the patient was kept alive only by stimulants, he says the trial of the warm bath was suggested to him by Mr. Smyly. "The effect was instantaneous and marvellous. The delirium ceased as if by magic. It was the delirium of pain; and the patient exclaimed, 'Thank God! thank God! I am in heaven! I am in heaven! Why didn't you do this before?' The fever immediately and completely disappeared, so that, on entering the ward, no one could suppose that there was a case of smallpox in it. He was kept at least seven hours in the bath." This case and its singular result, in addition to the experience of Hebra, justify the recommendation of the use of the bath.

MODIFICATION OF THE ORDINARY TEST FOR THE BILIARY ACIDS.—M. Strassburg, of Bremen, suggests (*The Practitioner*, February, 1872; from *Pflüger's Archiv für gesammte Physiologie*, Heft. x. and xi., 171) a modification of Pettenkofer's test for the presence of biliary acids in urine, which promises to be serviceable clinically, and, according to his statements, is of extreme delicacy, enabling a trace not exceeding $\frac{1}{100000}$ ths to be readily detected. He dips a slip of filtering-paper into the urine suspected to contain the biliary acids, and to which a little cane-sugar has been previously added. The slip is withdrawn and dried; a drop or two of pure concentrated sulphuric acid is now applied to it by means of a glass rod. On holding the paper up to a strong light, a beautiful violet color makes its appearance.

PRECOCIOUS DEVELOPMENT.—Flügel describes (*British Medical Journal*, February 24; from the *Bayr. Aertl. Intell.-Blatt*, No. 49, 1871) the case of a female child who died of diarrhoea at the age of five and a half years. She was five feet in height. The incisor teeth had all appeared when she was six months old, and at nine months she had all the molars. At a year and a half old she menstruated, and, especially in her later years, the periods were tolerably regular. The external genital organs were well developed, without hair; the breasts were full, and the pelvis roomy. The condition of the internal genitalia was not ascertained. As regarded her intel-

lect, she did not appear to be in advance of other children of her age, although she had begun to speak when six months old.

QUINIA AND DIGITALIS IN HEMICRANIA.—M. Debout (*The Practitioner*, February, 1872; from the *Journal de Médecine*) has obtained favorable results from the combination of quinia with digitalis in the treatment of migraine. The formula he employs is, sulphate of quinia, forty-six grains; powdered digitalis, twenty-two grains; of syrup, q.s., to be made into thirty pills, of which one is to be taken every evening. M. Gauchet states that he also has had frequent opportunities of treating hemicrania in this manner. In old-standing cases it is occasionally ineffectual. He obtained the best results in those cases where the attacks occurred at the menstrual periods.

IMPALEMENT OF ABDOMEN AND THORAX, WITH DISSECTION TWENTY YEARS SUBSEQUENTLY.—About eighteen years ago, Dr. Joseph Sargent, of Worcester, reported to the Boston Society for Medical Improvement (*The Boston Medical and Surgical Journal*, February 22) the case of a woman who, in sliding down hay from a loft, was impaled on the handle of a pitchfork, which entered the body through the vagina to a distance of twenty-two inches, where it was arrested by the upper left rib, which it apparently broke, and by the woman's feet reaching the floor. The woman recovered, and lived for twenty years after the accident. At the autopsy, the cavity of the left chest was found to be completely filled with the proper contents of the abdomen. These were afterwards ascertained to be the stomach, the transverse colon with a few inches of the descending colon, and a considerable portion of the small intestines. All these had passed through an opening in the diaphragm to the left of the median line. The callus of fracture of the first rib on the left side was quite conspicuous. The left lung was compressed to the thickness of the hand. It had also contracted adhesions with the stomach. The heart was crowded to the right of the sternum. On removing the contents of the abdomen, a large, irregular cicatrix was quite obvious in the peritoneum of the left rectouterine cul de sac. None of the viscera appeared to have been injured.

PROLONGED EXPIRATION.—Dr. Samuel G. Armor (*New York Medical Journal*, March, 1872), in the course of an article on the Physical Cause of Prolonged Expiration and its Relation to Consumption, says that it frequently occurs in the pretubercular stage of phthisis. It may have its origin in an error of nutrition entirely independent of tubercular, bronchial, or emphysematous complications. This error may be general or local. In the first case, the contractile power of the muscular and elastic fibres of the lungs participates in the universal failure of nutrition. Hence the existence of the sign during and after exhausting diseases. In the second case, the natural resiliency of the lung-tissue may be simply the result of a local condition, in which no tubercles have been deposited or no degeneration of the lungs has taken place,—a condition which may be expressed by the term "weak lungs."

ALTERATIONS IN THE NON-STRIATED MUSCULAR FIBRES OF THE SKIN.—The changes of the smooth muscular fibres in certain diseases of the skin have been studied by Neumann, Derby, Rossbochtz, and Köbner (*New York Medical Record*, February 1, 1872; from *Allgem. Wiener Med. Zeitung*). In variola, tumefaction of these fibres may be met with in examinations on the level of the pustules. This form of hypertrophy differs from that met in lichen, ichthyosis, elephantiasis, prurigo, and sclerema in adults, as has been demonstrated by the above gentlemen. In these latter cases it is not easy to determine if the hypertrophy is simple or multiple; in fact, the fibres, like the nuclei, are hypertrophied, and the muscular fascia becomes more voluminous throughout. This augmentation of volume is, without doubt, consecutive. Derby thinks it is due to exaggerated contractions of the non-striated muscular fibres, whose function it is to express the secretions from the sebaceous follicles. In specimens which are quite contracted, these changes seem to involve the whole thickness of the muscular layer, there appearing to be in some cases a new formation of these elements.

The organic muscles sometimes undergo atrophy. This

also takes place in both fibre-cells and nuclei, a fine granular matter being deposited, which, with the cell-contents being later absorbed, leaves the fibres and nuclei collapsed. This latter process is characteristic of senile atrophy of the skin.

INNERVATION OF THE HEART AND BLOOD-VESSELS.—Prof. Wm. Rutherford, in his admirable lecture on Experimental Physiology in the *Lancet* for December 16, 1871, and January 20, 1872, shows that within the heart there is a reflex nerve mechanism, consisting of cells connected with intra-cardiac and extra-cardiac nerves; the former being cardio-motor and excitocardio-motor, the latter cardio-inhibitory. The extra-cardiac nerves are branches of the vagus and sympathetic, and both are connected with the medulla oblongata. Both nerves transmit their influence to the heart, the sympathetic accelerating the cardiac action, the vagus inhibiting or retarding it, and, if powerfully stimulated, even for a time completely arresting the cardiac contractions, the heart during the rest being dilated. The branch of the vagus which does this is, in rabbits, the inferior cardiac.

The superior cardiac branch of the vagus is the sensory nerve of the heart, and is also an inhibitory nerve, but inhibitory for the blood-vessels; that is, when it acts it brings the contractile elements in the blood-vessels into a state of rest, thereby causing dilatation. Thus, while the inferior cardiac branch of the vagus is cardio-inhibitory, the superior cardiac is vaso-inhibitory. The former transmits its influence from the medulla oblongata to the cardiac ganglia; the latter transmits its influence from some portion of the heart to the medulla.

The vaso-motor nerves are immediately derived from the sympathetic; but Ludwig and Thery have shown that the nerve-cells presiding over them are not contained in the sympathetic ganglia, but in the medulla oblongata, which is therefore the seat of the general vaso-motor centre; general, for possibly there are special vaso-motor centres in the submaxillary ganglion and in the ganglia found in the penis. The vaso-motor nerves leave the spinal cord in the anterior roots of the spinal nerves, whence they either pass through, or receive branches from, the ganglia upon the sympathetic, and proceed to the blood-vessels. The general vaso-motor centre in the medulla oblongata appears to be in almost constant action, thereby keeping up some degree of contraction in the blood-vessels. But its action may also be diminished, the effect of which is diminished contraction or complete relaxation of the vessel. The vaso-motor nerve being for the time paralyzed, the walls of the vessel relax, and the blood-pressure and elasticity open up the vessels. The nerves which do this Dr. Rutherford calls vaso-inhibitory nerves, corresponding to the cardio-inhibitory. The most remarkable vaso-inhibitory nerve we know is that already alluded to as such,—the superior cardiac branch of the vagus in the rabbit. If we divide this nerve and stimulate its central end, we cause a remarkable lowering of the blood-pressure, owing chiefly to dilatation of vessels in the abdominal viscera and lungs (Ludwig and Cyon). The inhibiting influence seems to be conveyed to the medulla. There are two instances in which vascular dilatation follows stimulation of the peripheral end of a nerve,—viz., the chorda tympani, and the nervi erigentes of the penis.

The application of these facts is made to nutrition in accounting for the vascular dilatation in active nutritive changes, which are accounted for by Prof. Rutherford by the action of these vaso-inhibitory nerves, instead of to a more powerful *vis a fronte*. Loven approximates the same idea when he shows that the blood-vessels of a part may be dilated by artificial stimulation of its different nerves, as in inflammation or irritation; but he restricted it to such phenomena as those of blisters, and did not extend it to nutrition.

ON THE USE OF LACTO-PHOSPHATE OF LIME.—Dr. R. Blacke calls attention, in *The Practitioner* for February, 1872, to the use of this salt in adynamic fevers and in convalescence. The want of success which has generally attended the employment of the phosphates he attributes to the fact that they are given in such quantities that there is not enough lactic acid in the gastric juice to dissolve them. He therefore recommends the administration of lacto-phosphate of lime, which he says is at once an aliment and an article of food, and a medicament of the highest value. It is, moreover, soluble in the secretions of the stomach, and is readily absorbable.

MISCELLANY.

THE ANNUAL COMMENCEMENTS.—The Jefferson Medical College held its annual commencement at the American Academy of Music, in this city, on Saturday, March 9. The degree of Doctor of Medicine was conferred upon 115 graduates. The valedictory address was delivered by Joseph Pancoast, M.D., Professor of Anatomy.

The annual commencement of the Medical Department of the University of Pennsylvania was held at the same place on Tuesday, March 12, when 83 gentlemen received the diploma of the Institution. D. Hayes Agnew, M.D., Professor of Surgery, made the valedictory address. The Dean of the Faculty, Dr. Rogers, announced that the thesis of Thomas Hunter, of Pennsylvania, "On Correspondence of Convolutions of the Brain with Markings on Interior of Cranium," and that of William T. Rogers, of Georgia, "On Hemorrhagic Malarial Fever," had been commended for their excellence, and that the Society of the Alumni had voted each of these gentlemen a present of fifty dollars.

The number of graduates at the College of Physicians and Surgeons, New York, at the Bellevue Hospital Medical College, New York, and at the Medical Department of the University of New York, are respectively 78, 129, and 75; in all, 282.

Thirteen women graduated at the Women's Medical College of this city, and only eight at the corresponding institution of New York,—so small a number that we are tempted to believe that the medical instruction of women, notwithstanding the notoriety that the supporters of the movement have succeeded in giving to it, and the special privileges that have been obtained for female students at the Pennsylvania Hospital, is not likely to be a success.

CHARTERS REVOKED.—Our readers will be glad to hear that the charters of the Philadelphia University of Medicine and Surgery, and of the American University of Medicine, were revoked on the 20th of March by a unanimous vote of both branches of the Legislature of this State. The testimony in reference to the sale of diplomas by these institutions, elicited by the committee of the Senate, was of such a convincing character that the Legislature could with honor to itself have taken no other course.

While we rejoice that Messrs. Paine and Buchanan, and the bogus colleges of which they were the presiding spirits of evil, are thus prevented from the perpetration of any further frauds, we cannot help regretting that no punishment is likely to be inflicted upon men who have abused the privileges which have been conferred upon them and brought disgrace upon the community in which they live. They are certainly also morally, if not legally, guilty of obtaining money under false pretences; for it was clearly shown that their scholarships were bought by young men who supposed that they were thus enabling themselves to attend the lectures delivered at the University of Pennsylvania.

The secular press of this city deserves the thanks of the medical profession for the pains it has taken to expose the evil and to force our legislators to take cognizance of it. We hope our contemporaries have learned from the investigation that all the so-called prejudices of regular physicians are not entirely without foundation, and that men who have emancipated themselves from the restraint of rules to which the honorable members of their profession cheerfully submit, are

not likely to be over-scrupulous in their conduct in matters concerning which the public is better able to judge of its propriety.

JOURNALISTIC CHANGES.—A new journal, to be called *The Washington Medical Monthly*, is announced. It is to be edited by Drs. S. C. Busey and William Lee, who, it will be remembered, recently dissolved their connection with the *National Medical Journal*, in consequence of the publishers insisting upon the insertion of an article of which they disapproved. The publishers seem to have had the interests of their advertisers more at heart than the advancement of medical science, and no other course than that of retiring was left to the editors. They have our most cordial wishes for the success of their new enterprise.

Messrs. Judd & Detweiler, the publishers of the *National Medical Journal*, announce that "its publication is temporarily suspended until arrangements can be consummated with some competent and responsible party to conduct its editorial department in a creditable manner." We think it, however, very unlikely that such a person will be found willing to undertake the editorial duties of a journal the publishers of which have shown so little respect for the rights of editors.

We have not received the last number of the *Medical World*, but learn from *The Medical Record* that it has also lost its editor. The cause of his retirement is not stated; the only information vouchsafed to us by the publishers is that "Dr. Reuben A. Vance, whose name lately appeared as editor, is no longer connected with the *Medical World*."

APPOINTMENTS OF SURGEONS TO THE WILLS OPHTHALMIC HOSPITAL.—At a meeting of the members of the Board of City Trusts, held March 25, Drs. Morton, Harlan, Dyer, Goodman, McClure, Keyser, Thomson, and Norris were duly elected Attending Surgeons to Wills Hospital. These gentlemen will enter upon their duties to-day.

DR. JAMES MARKOE has been elected Attending Physician to the Presbyterian Hospital, *vice* Dr. John F. Meigs, who declined the appointment. Dr. George S. Gerhard has been appointed pathologist to the same hospital.

A NEW JOURNAL.—We have received the second number of *The Western Lancet*, a new monthly medical journal, edited by Drs. Eustace Trenor and Heman P. Babcock, and published under the auspices of an association of physicians at San Francisco. Among its leading features, the prospectus states that "at least one photograph from nature of a pathological specimen or surgical case will accompany each number." The journal promises to be a good one.

THE FINITE AND THE INFINITE.—A lady has written to the Academy of Sciences in London that she has at last found the principle which differentiates the finite from the infinite. She demands that five other Academies shall join the Academy of Sciences, and that together they shall pay her the sum of one million pounds sterling. At this price she will yield up her secret.

ROYAL VICTIMS TO SMALLPOX.—Dr. John Gardner (*New York Medical Journal*; from the *Edinburgh Medical Journal*) has collected the following history of the ravages of smallpox in some of the royal houses of Europe, hoping thus to impress the public mind more forcibly as to the advantages of vaccination:

Among the family of Charles I. of Great Britain, of his

forty-two lineal descendants up to the date of 1712, five were killed outright by smallpox: viz., his son Henry, Duke of Gloucester; and his daughter Mary, wife of the Prince of Orange, and mother of William III.; and three of the children of James II.: viz., Charles, Duke of Cambridge, in 1677; Mary, Queen of England, and wife of William III., in 1694; and the Princess Maria Louisa, in April, 1712. This does not include, of course, severe attacks, not fatal, such as those from which Queen Anne and William III. suffered. Of the immediate descendants of his contemporary, Louis XIV. of France (who himself survived a severe attack of smallpox), five also died of it in the interval between 1711 and 1774: viz., his son Louis, the Dauphin of France, in April of 1711; Louis, Duke of Burgundy, son of the preceding, and also Dauphin, and the Dauphiness, his wife, in 1712; their son, the Duc de Bretagne, and Louis XV., the great-grandson of Louis XIV. Among other royal deaths from smallpox in the same period were those of Joseph I., Emperor of Germany, in 1711; Peter II., Emperor of Russia, in 1730; Henry, Prince of Prussia, in 1767; Maximilian Joseph, Elector of Bavaria, Dec. 30, 1777.

THE REPORT OF THE SUPERVISING SURGEON, UNITED STATES MARINE HOSPITAL SERVICE.—We make the following extract from this report:

Statement of the operations of the Marine Hospital Service for the six months ending December 31, 1871, as compared with the six months ending December 31, 1870.

SUMMARY.

	1870.	1871.	Difference.
Number of patients treated in hospital.....	8,151	7,257	
Number of days of hospital relief.....	224,023	199,854	
Average number of patients maintained daily.....	1,231	1,098	
Percentage of deaths.....	3½ per ct.	3 per cent.	
Expenditures incurred for care and treatment of sick and disabled seamen.....	\$235,159 05	\$195,109 04	
Cost per diem for each patient.....	\$1 05	\$0 97.6	
Diminished expenditures during the six months ending December 31, 1871.....			\$40,050 01
Diminished percentage of expenditures during the six months ending Dec. 31, 1871, compared with the six months ending Dec. 31, 1870.....			17 per ct.
Amount of hospital-tax collected.....	\$126,427 77	\$138,947 23	
Increase of hospital-tax collected during the six months ending Dec. 31, 1871.....			\$12,519 46
Number of ports where hospital relief was furnished.....	75	75	
Number of ports where hospital-tax was collected.....	118	119	

* These figures represent the minor portion of the tax collected each year, the major amount being collected during the last six months of each fiscal year.

NAVY NEWS.

LIST OF CHANGES IN THE MEDICAL CORPS OF THE NAVY SINCE MARCH 6, 1872.

Assistant-Surgeon A. F. PRICE detached from the Juniata, and granted leave.
 Assistant-Surgeon PAUL FITZSIMMONS ordered to the U.S.S. Saranac.
 Assistant-Surgeon R. A. MARMION detached from the Saranac, and ordered home.
 Assistant-Surgeon P. P. BIRLBY ordered to the Naval Hospital, Norfolk, Virginia.
 Surgeon P. S. WALES and P.-A.-Surgeon H. M. RUNDLETT detached from the U.S.S. Guerriere, and waiting orders.
 P.-A.-Surgeon JOS. HUGG promoted to Surgeon.
 Dr. R. C. PERSONS appointed Assistant-Surgeon.
 Assistant-Surgeon WM. B. DAVIS to the U.S.S. Tallapoosa.

MORTALITY FROM SMALLPOX IN PHILADELPHIA.—The number of deaths from smallpox in Philadelphia for the weeks ending March 16 and 23 were respectively 120 and 94, of which 151 were of minors.

MORTALITY OF PHILADELPHIA.—The following reports are condensed from the records at the Health Office:

	For the week ending	
	Mch. 16.	Mch. 23.
Consumption	52	56
Other Diseases of Respiratory Organs	56	58
Diseases of Organs of Circulation	22	22
Diseases of Brain and Nervous System	58	60
Diseases of the Digestive Organs	30	22
Diseases of the Genito-Urinary Organs	8	7
Zymotic Diseases	151	116
Cancer	6	5
Casualties	5	5
Debility	29	29
Intemperance	5	0
Old Age	14	3
Scrofula	2	1
Stillborn	14	15
Suicide	0	1
Syphilis	0	1
Tetanus	1	0
Unclassifiable	5	14
Unknown	1	2
Totals	459	427
Adults	214	192
Minors	245	235

OFFICIAL LIST

OF CHANGES OF STATIONS AND DUTIES OF OFFICERS OF THE MEDICAL DEPARTMENT U. S. ARMY, FROM MARCH 5, 1872, TO MARCH 18, 1872, INCLUSIVE.

EDWARDS, L. A., SURGEON.—By S. O. 63, War Department, A. G. O., March 14, 1872, relieved from duty in Department of Texas, to proceed to Philadelphia, Pa., and thence report to the Surgeon-General.

HAMMOND, JOHN F., SURGEON.—By S. O. 63, War Department, A. G. O., March 14, 1872, to report to the Commanding General, Department of Texas, for duty as Medical Director.

WIRTZ, H. R., SURGEON.—By S. O. 60, War Department, A. G. O., March 12, 1871, upon arrival of Assistant-Surgeon Girard in Department of Arizona, to report to the Commanding General, Department of California, for assignment to duty.

BACHE, DALLAS, SURGEON.—By S. O. 57, War Department, A. G. O., March 7, 1872, relieved from duty in Department of Texas, and to report in person to the Surgeon-General.

ASCH, M. J., ASSISTANT-SURGEON.—By S. O. 61, War Department, A. G. O., March 12, 1872, granted leave of absence for six months.

McELDERRY, H., ASSISTANT-SURGEON.—By S. O. 61, War Department, A. G. O., March 12, 1872, after accompanying the first detachment of recruits sent to the Pacific Coast from New York, to report in person to the Commanding General, Department of the Columbia, for assignment to duty.

GIRARD, JOS. B., ASSISTANT-SURGEON.—By S. O. 60, War Department, A. G. O., March 11, 1872, to report to the Commanding Officer, Department of Arizona, for assignment to duty.

KIMBALL, JAS. P., ASSISTANT-SURGEON.—By S. O. 33, Headquarters Department of the Gulf, March 4, 1872, assigned to duty at Little Rock, Ark.

MOFFATT, PETER, ASSISTANT-SURGEON.—By S. O. 60, War Department, A. G. O., March 11, 1872, assigned to temporary duty at Newport Barracks, Ky.

KING, J. H. T., ASSISTANT-SURGEON.—By S. O. 62, War Department, A. G. O., March 13, 1872, to report to the Commanding General, Department of the Platte, for assignment to duty.

CORSON, J. K., ASSISTANT-SURGEON.—By S. O. 20, Military Division of the Missouri, March 14, 1872, leave of absence extended thirty days.